The Canadian Nurse

A Monthly Journal for the Nurses of Canada
Published by the Canadian Nurses Association

Vol. XXV. WINNIPEG, MAN., OCTOBER, 1929 No. 10

Registered at Ottawa, Canada, as second-class matter

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Editor and Business Manager:—
JEAN S. WILSON, Reg. N., 511 Boyd Building, Winnipeg, Man.

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The Citizen in Relation to the Public Health Programme

By HELEN R. Y. REID, LL.D., B.A., Montreal

The citizen's contribution may be in the form of active participation in some of the local or national nursing services, mental or social hygiene councils, child welfare centres and guidance clinics, in parent-teacher groups, health, education and recreation associations, work for crippled children, occupational therapy, fresh air camps and the like. As presidents, board directors and committee members their duties are manifold. These include not only the raising and administering of funds, but also representing the organisation and interpreting to the subscribing public its functions and the part it plays in the larger health programmes of the community. We also find men and women of vision and courage demonstrating the need of new health-giving measures and under professional direction establishing and carrying on such work. In addition, the volunteer is frequently doing specific supplementary duties, such as clerical and motor service, writing reports, speaking, interviewing, etc. This active participation by the volunteer citizen discloses the importance of the definition of relationships between him and his professional partners if the work undertaken is not to be hampered by mistakes due to over-zeal, indifference, ignorance or lack of co-operation. Possibly the time necessarily spent in the past on building up the technique of professional standardisation, procedures and routine, in adjusting relations between the various nursing and medical professions, might now be spent, in part at least, in developing the technique of working with volunteer committees and with the official representatives of public health in the community. Active participation also develops the sense of partnership, of team play, which goes so far towards the realisation of a true community consciousness, the desired aim and end of all organised community work.

The citizen may also make another contribution to the health programme of the community—that of personal hygiene. Sir George Newman tells us "There can be no public health apart from individual health. This cannot be conferred or imposed by the state. It must be a matter of individual achievement, though the individual may be helped and taught by the state." The wide dissemination of health information, inclined to be propagandist rather than educational in presentation, and sometimes unbalanced and ill-informed, causes a certain degree of confusion in the citizen's mind. "The things we are advised to do in respect of clothing, diet, etc., are so numerous and varied that we incur some risk of not knowing what course to adopt, what to accept and what to decline, and consequently of doing nothing. Year by year, transmission of such knowledge should be more exact and its application more in accord with the best kind of human experience." Sir George goes on to say that "Personal health is not an accomplishment but a growth—a growth which depends on the nature of the individual, his constitution, and its sound nurture. Nature and nurture lie at the foundation of all true growth, and all true health, and they are mutually inter-

(A paper read at a Public Health session, Sixth Congress, International Council of Nurses.)

related. We cannot select our parents, nor change essentially our germ plasm or the character and formation of our bodies. This is our inheritance for better or worse. We can, however, study to know and understand our capacities and tendencies, and this is the first step to personal health. We can also ensure to succeeding generations better stock or constitution. Sound mating is the beginning of good breeding —unwise mating is a source of enfeebled health, of unstable disposition or even of disease. It is also possible that individual immunity and the chemical constituents of the body may be transmitted from parent to child." The citizen should consider more seriously these latent forces of heredity which have probably as much to do with personal health as any other factor. It is still more futile to neglect the proper nurture of the body. The body is not a machine but a growing organism with its own individual tendencies, idiosyncrasies and susceptibilities. Age, sex and circumstances should govern methods of personal hygiene. What is now common knowledge about food, fresh air, exercise, warmth and rest should become common practice—the daily practice of the physiology of the body, not only that it may perform its daily work, but be able to withstand the strains and infections to which it will inevitably be subjected.

If the citizen wants to be well and to keep well, let him ask his hospital or physician for periodic physical examination. By creating a demand for such examination the citizen will hasten the day when the rank and file medical practitioner will in turn demand university training for the promotion of health as well as for the cure and treatment of those who are ill. May not the citizen seek, too, a quickened enthusiasm with regard to personal health, and cultivate for our young people admiration for strong, enduring, robust types who have done and are doing great things in human history?

Again, the citizen who is neither poor enough nor rich enough to obtain adequate medical and nursing care may hope that the socialisation of the medical and nursing profession, partly through field observation in the home, will precede the dawning of the day of state health insurance where this does not yet exist, so that exorbitant and impossible demands on individual and domestic resources will not be made by highly trained professionals unfamiliar with the conditions under which their patients live.

If he is active in health work, the citizen will realise that public health officials and health experts are human beings and citizens like himself. Doctors, nurses, public health officials and other awe-inspiring health authorities do not fulfil their duties as citizens if they forget in their busy, generous days what the ultimate aim of their service is, namely, not only the cure of the individual but the sharing with him the newer responsibility of preventing disease and of promoting the health of the entire community.

Problem

In the title of the address assigned to me we may find, if we will, an age-old problem, which is still awaiting solution. This is the problem as to whether the good of the state is a higher good than that of the individual. Is this a conflict between irreconcilable opposites or is it a manifestation of two legitimate ways of living which await interpretation, reconciliation and synthesis?

Public and private or voluntary health organisations exist side by side today in most civilised countries. The citizen may be mystified at what at times appears to be an overlapping of activities, he may therefore be distressed at the apparent waste of time, thought, energy and money, particularly when he is finding it increasingly difficult to pay for medical and nursing care himself, but he must acknowledge that as a result of the organised application, both private and public, of the findings of medical

research, nursing studies and preventive medicine, the life of the ordinary man has been lengthened by many years, and those years have been rendered more free from the terrors of communicable and other dread diseases. The citizen, in the last analysis, bears the burden of illness and pays for all health service. He may therefore reasonably inquire whether the time is not ripe for systematic co-ordination, controlled or voluntary, of all health programmes and for directed co-operation of all health organisations.

All are agreed on the value of health. Our value to the state is incalculably enhanced by a high standard of health. Positive health is, truly, more than freedom from disease. "Positive health," as Professor J. Arthur Thompson tells us, "includes vigour, resisting power, capacity for initiative, clear-headedness and *joie de vivre.*"

Any consideration of the present trends of health service must take into account the historical and political developments as well as the environment and conditions of the population in whose countries such health work is being done. No judgment or even an approximate estimate of the value of such service can be rendered unless these larger factors—including variations in conditions in different parts of the same country—are taken into account, for the historical and local setting affect very greatly the character of what is termed the public health programme, as it does that of health work undertaken by the private or voluntary agencies, and the relationship of both of these very definitely, in turn, affects for good or ill the health of the individual and that of the community.

The great undertaking of the doctor and the nurse, of the research worker and the health organisation, be it public or private, is, then, to prolong man's days by reducing premature mortality, to remove the cause of disease and its results, and to enhance the physical and mental capacity of all classes of people.

Public and voluntary health work exist side by side as an outward expression of this interest, impelling both the state and the citizen group to undertake health work. The progress made in medical science and research into the causes of disease and their cure has made preventive methods general and has set on foot a parallel movement in all countries. Preventive methods, first developed by private organisations, have had great influence on the state, which is now undertaking preventive work partly as an obligation laid down by law and partly as voluntary effort causes the boundary line between public and private health work to become a fluctuating one. Hence, many of the causes of irritation and misunderstanding between the two!

It is symptomatic today that progressively minded governments are going far beyond their legal obligations in the development of preventive work. It is recognised as a law of evolution that efforts originally initiated by private enterprise are taken over by the municipalities as soon as public opinion recognises the need for them. The original agencies, be they for child welfare, public health nursing, tuberculosis or other health work, experience very natural regret at handing over to public authorities work built up through years of painful effort. The private organisation often makes the criticism that the transfer does not always guarantee higher standards of work, improved administration and better service for the individual, and, most important of all, that doctors and nurses who are authorised agents paid by the state or public authority are not filled with the personal devotion to their calling that is supposed to characterise the private agency worker. There may be some truth in this, but possibly it should be a matter for pride rather than discontent on the part of the private agency that its work has been recognised and

thus made available in a much wider and more extended form. We must admit, however, that while the private agency may and does select its clientele, the public organisation, under a legal and publicly organised obligation, has to consider general interests and great numbers of people. This demands much division and subdivision of work, which may easily degenerate into official routine, and renders individual work more difficult. When politics interfere, there are indications at times that the expansion of the public health field is consciously directed against the private agency.

Field of Public Health

It is now an established fact that sanitation, food control, communicable disease control and improved environment are the foundations on which the superstructure of other public health services stand. To local public authorities have been given many statutory duties in respect of sanitation, nuisances, water supply, food control, river polluting, housing, communicable diseases, hospital accommodation and so forth. Following these we have a duty recognised as belonging to the state of ascertaining what the situation is—the notification of births and infectious diseases, the certification of sickness and the registration of death. Here the citizen may give co-operation by helping to make these records adequate and correct. We recognise, too, the state's obligation in the matter of industrial legislation. Factory Acts and workmen's compensation, not primarily of state origin, are now under state control—though here, in this field, we see the voluntary organisation of employers or employed supplementing and sometimes going in advance of government in preventive and constructive health measures. However, it is when we reach the field of maternity and child welfare, of personal hygiene, of the control of special diseases, of research, of demonstration, of all that is included in the word *Nurture*, that we find the latest manifestations of governmental endeavour in preventive health work. The question, therefore, follows—should there be a systematic division of service, an effective delimitation of the actual fields of work between the two agents, public and private? If such division is not possible, should there not be co-ordination and co-operation? In either case, who is to take the initiative in instituting the necessary measures? On which agency should this responsibility best fall?

A serious factor to be considered here is the immense number of both kinds of organisation, public and private, collective and independent, in almost every country. We find, as a result, that there is a growing tendency both in Europe and America towards establishing local, national and even international Leagues, Unions or Councils of Health and of Social Welfare. This removes some of the difficulties due to friction and misunderstanding, and makes interpretation and actual inter-relationship with official agencies easier and more effective. In the western world this consolidation of interests of individual agencies comes not from government control but from the recognition of the need by the agencies themselves, a healthy and truly democratic development.

A closer relationship to governmental bodies is often indicated through the subsidising on a service basis of the voluntary organisations by the state, a very general practice in America and one that has both good and bad effects. Hospital service is frequently provided in this way, and so the question is often asked why district nursing service for those who cannot go to hospital, who cannot afford to pay and who are not under a government insurance scheme, should not receive a similar recognition on a per capita per diem cost basis. When the state actually transfers some public health duties to a private organisation, as in the case of Hungary and the Red Cross, systematic financial recognition naturally

follows, with resultant economy to the country, for it is nearly always found that administration and running costs are considerably less in the voluntary organisation.

In the western world the pioneer tradition is still strong. The love of discovery, the eagerness to be doing something, lead the people to welcome change and to share in the change. Decentralisation and individualism, therefore, characterise much of the social welfare undertaken in Canada and the United States. Instead of state health insurance protecting over fourteen million workers in Great Britain and over eighteen million men and women in Germany against illness, and providing for them both cash and medical benefits of various kinds—instead of a controlled partnership between the state and the medical and nursing professions, so distinctive of Germany, Japan, and of Great Britain to a somewhat lesser extent, we have in our western world an astounding number and an extraordinary variety of independent voluntary health organisations attempting in their scope to cover national, provincial or state, as well as local health needs. The surmise has been ventured by an American public health authority that such a development is due, in addition to the qualities of youth referred to a moment ago, to the fact that in the new world the sense of community responsibility is greater in the individual man in the street than it is in those who occupy positions of authority in government—that the civil servants of the best European countries are more trustworthy and efficient than they are in the United States, and that therefore if Americans want enhanced health they must undertake most of the activities and responsibilities towards this end themselves. Be that as it may, the contribution made by voluntary health agencies in America, particularly in the demonstration, survey, research and more especially in nursing fields, is without a parallel in the world's history.

In its new bibliography the Department of Surveys and Exhibits of the Russell Sage Foundation lists no fewer than 2,700 surveys. Those in Health (458) and Education (582) top the list. The Cleveland Health and Hospital Survey is one example of the many outstanding contributions in this field. Two universities and four national health organisations participated in this survey on the invitation of the twenty-one institutions organised in the Cleveland Hospital Council, all those interested being voluntary organisations. Other specialised community health surveys by private organisations have been applied to special divisions of health requirements, such as tuberculosis needs and resources.

Paul U. Kellogg, Editor, *The Survey,* and Dr. Neva R. Deardorff, director, Research Welfare Council, New York City, reporting for "Social Research as applied to Community Progress" at last year's International Conference on Social Work held in Paris, tell us also something of the research work undertaken by the great American foundations, of which 150 were listed in 1926. This great flowering out they attribute to the cross fertilisation of the scientific spirit with social consciousness, and to the rapid advances in personnel and technique, idealogy and experimentation. The "fertilisers" themselves also receive their just tribute of praise. With so much effort, time, money, under expert voluntary direction in research in health, the question is raised whether any stultifying effect follows in university and in public health domains. Apparently not, for the statement is made that this kind of citizen interest, this research work fostered by the great foundations, have actually stimulated government activity, both federally and in the states, as is seen in the work of the numerous government health commissions recently appointed. Neither have the universities given up their creative scholarship and research work. They have, instead, be-

come stimulated to undertake new work in new directions. Thus knowledge has been trebly advanced.

One cannot help apprehending the limitation upon freedom of thought and action when great funds and the tremendous power that goes with them are placed in the hands of a small group. Directors are apt to attempt the direction of opinion—the cast of thought rather than the encouragement of thought. Perhaps such directors—be they foundations, university or state governors—should themselves be surveyed and studied in order to see whether with their giant opportunities they are really facing and exploring our giant social problems, or if with directed discretion they are neglecting these for the consideration of problems less urgent and of less importance.

In addition to the voluntary enterprise in surveys, demonstrations and research of the great foundations there are, in the western world, a confusing number of independent health associations. Most of them are doing good work and some of them are connected, loosely, it is true, with other organisations having health, education or welfare work as their objective. If recognised by the state through grants or subsidies, there is little if any attempt on the part of the government to guide or co-ordinate these independent efforts. We cannot be blind to the dangers of gaps left unfilled, of duplication that so often may occur when an individual agency, limited in authority and resources, in outlook and policy, undertakes community health service. The special opportunities of the voluntary agency are, truly, those of pioneering, experimenting, demonstrating and popularising new health measures and higher standards of work. Experience has already taught them some of the advantages of co-operation. Is there not a further step now needed in the direction of systematic co-ordination of the work of all agencies, both public and private, that are doing health work? With the increasing complexity of civilisation and the tremendous "machineries of existence" which are conditioning the life and labour of all of us, is not such systematic co-ordination of a continuous kind not only desirable, but, every day and every year, becoming more and more necessary?

In Europe, the modern tendency at work demands the intervention of the state because of the recognition of the fact that the social ills they are trying to combat are the results of defects in the whole social and economic order. In that older land there has grown up a feeling of collective responsibility and a recognition of the need for centralised control, intensified since and because of the war to the end that the state, by means of legislation and administration, may act both as guardian and as agent of the welfare of the people. State insurance against ill-health, old age, accident and unemployment makes provision for such hazards as affecting the lives of the citizens.

Organised co-operation with systematic co-ordination of health and welfare work by the state may come about either by legislation or by voluntary agreement. We find it since the war in different stages of development in Holland, Poland, Italy, Sweden, Germany and Japan.

A typical example may be quoted in Germany's legislation of 1924-25 regulating the co-operation of public and private welfare organisations. The Reich law on health insurance provides a basis for the combination of the individual agencies doing insurance work for sickness, disablement and employees' insurance, and for their co-operation with agencies of public and voluntary welfare, primarily those interested in tuberculosis and venereal disease. The local welfare offices are responsible for the conduct of welfare work and have to form a liaison between the public and the voluntary organisations. They aim at getting the public and voluntary

organisations to supplement each other's activities and to collaborate in such a way that each will preserve its own independence. The Reich committee for health propaganda has under its guidance state committees which decide on forms of organisation, local committees which carry on the work of instruction, and district centres for the country districts and small towns. On the Reich committee are representatives of the medical profession, the insurance societies, the Red Cross, and voluntary associations for different branches of health service.

This European example of detailed control and supervision is in striking contrast to the less regulated relationships between western public and private organisations doing welfare work. We are thus brought once again face to face with the problem which is implicit in the title of the address, the apparent opposition of the ideals of independence and co-operation, of the individual as opposed to the collective way of doing things. We are more ready, perhaps, to agree that these ideals are not mutually exclusive, but that they are manifestations expressed in different and largely unrelated ways, of one and the same ideal.

We recognise that historical and environmental factors account in large measure for the diverse developments in health work in different parts of the world and in different parts of one and the same country. In the light of history we can see the gradual emergence from primitive conditions of all forms of public authority and government, the individual citizen or citizens repeatedly taking the initiative with a courage sometimes born of despair and with truly heroic persistence in instituting reforms for safeguarding the life and well-being of the people. We acknowledge the present-day need for increased division of labour, for specialisation in science, for detailed and accurate research in medicine and public health, but are we not also acquiring more and more the sense of collective responsibility? Do we not feel that team play is needed, and that citizen, doctor, nurse and public health official are all partners in the great adventure of healthy living? We see both forms of health service —public and private, independent and collective—working side by side, at times with friction and without co-operation, at times displaying amazing success or inexplicable failure. We know that both ways have their rewards and both have their dangers. For certain purposes, at certain times, and given certain conditions, the enlightened citizen will recognise that the particular end in view requires independent specialisation of work; and at other times he will see the need for synthesis, for generalisation, for application of the facts to a collective purpose.

"Seeing health needs sanely and seeing them whole" is perhaps, then, the chief contribution, as it is the most difficult, which the citizen can make in relation to the public health programme.

Editorial

1908—1929

Twenty-one years ago on October 8th, representatives from sixteen nurses' associations in Canada met in Ottawa and founded the Canadian Nurses Association.

Today we may well pause to pay tribute to those women who accepted the challenge to organise the numerically small group of nurses in the Dominion then active in nursing. Those women recognised the need for some means whereby the members of the profession could be provided with a bond which would unite them nationally: and a national organisation was the logical means. An organisation whose "objects" were (and still are): to encourage mutual understanding and unity among the nurses of Canada; to advance the educational standards of nursing; to maintain the honour and status of the nursing profession; to acquire a knowledge of methods of nursing in every country; to afford facilities for international hospitality and to encourage a spirit of sympathy with the nurses of other countries.

A review of the past years reveals that these aims have been accomplished and it is for us to carry into the future all that is best from those years of our organisation and to value what has been achieved to place us in the fortunate position in which we are today.

To render tribute is not enough. It is for us to "take stock" of what lies immediately ahead. There is much that requires the unity and enthusiasm of each one of us.

Very soon there will be commenced the actual study of nursing as agreed upon by the Canadian Medical Association and the Canadian Nurses Association. It is recognised that present conditions require this study. It must be kept in mind that the benefits eventually derived shall be in proportion to the interest shown by the individual nurse.

Then there is the troublesome question of "Dual Membership" in the national organisation. The special committee appointed to make a study of this vexatious condition has attempted to interest all associations involved. Now is the opportune time for these associations to express an opinion as to their desire to have present membership continued or to make suggestions in regard to what other plan they wish adopted.

Plans are already in operation for the Biennial Meeting, 1930, which is to be held in Regina, Saskatchewan, while several committees are busily engaged with inquiries affecting Nursing Education and Schools of Nursing.

As associations of nurses re-open for this season's meetings may they remind themselves of their professional obligations: many members of these associations attended the Sixth Congress of the International Council of Nurses, and now possess an enthusiasm born of the wonderful experience which should infuse a new spirit, and develop clearer thinking and vision into those ideals which are our inheritance.

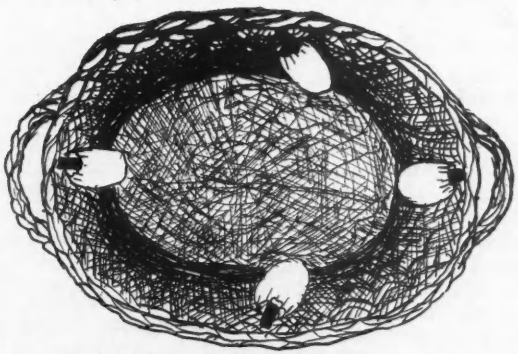
Let our united objective be: the progressive unfolding of a Canadian Nursing Profession and Service—one which shall be a joy to those who belong as well as to those who are served.

Care of the Premature Infant

By EDGEWORTH MURRAY, Supervisor, Children's Department, Royal Alexandra Hospital, Edmonton

Premature and very small infants have a large body surface according to their bulk, therefore, the evaporation of body heat is more rapid, and, in order to conserve this, it is necessary to keep them extra warm. The temperature of the environment should be about 80 degrees F.: some authorities say from 70 degrees to 80 degrees, and others from 80 degrees to 90 degrees. This air should be fresh with a humidity of 55 degrees percent, and an air space of about 1,000 cubic feet.

In the modern children's ward scientific methods of structure as well as heating apparatus make the problem of uniform warmth with humidity more possible, but where such conveniences are not available methods must be contrived by the nurse to meet these needs. The use of incubators is gradually being discontinued, as they were found complicated and unreliable unless constantly watched—the ventilation in them was usually poor, and the humidity too low.



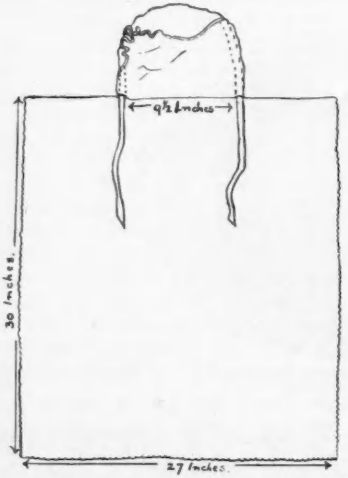
No. 1—Clothes basket with flannel bags containing bottles for hot water.

A cheap simple satisfactory bed may be made from a clothes basket 30″ long, 22″ wide and 18″ high (Diagram No. 1), having a padded lining, and using a pillow for a mattress. About six or eight small pockets can be made in the lining to hold glass bottles of hot water; these are left uncorked to supply the necessary moisture in the atmosphere when a blanket is placed over the basket. The water in these bottles is 115 degrees F., and they are changed one at a time in order to prevent the temperature of the infant oscillating, which of course uses up the infant's energy. If the glass bottles are not used, rubber hot water bottles take their place, and the water is the same temperature. Additional moisture will be required then; this may be obtained by putting a pan of water on the radiator or by having a small electric stove and steam kettle.

A thermometer is wrapped up in the baby's blankets and this is kept at 80 degrees F. The infant's temperature is most desirable at 99° degrees. Anyone who has cared for premature infants can appreciate the difficulty of maintaining this temperature. Each time his temperature is taken he is turned from side to side and on his back. Only those in attendance on the infant are permitted in the room. The nursery light is of course subdued, and noise is taboo. It is wise to have a No. 10 French catheter on hand with oxygen in case of cyanosis.

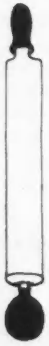
No premature or very small infant can stand much handling, as it produces shock. They are cleansed each day or every other day, as the doctor wishes, by using warm olive oil. The nostrils and lips are kept moist with sterile vaseline or olive oil. The nurse's hands and everything that comes in contact with the infant is first warmed. The infant is weighed in his soiled flannel jacket, and then lifted gently into his fresh warm one, exposing as little as possible of his small body. The soiled jacket is then weighed and the correct weight determined.

The clothing of the premature infant in former days consisted of a



No. 2—Flannel cape for premature baby.

padded jacket made of absorbent cotton and gauze. This is now replaced by a similar jacket made of flannel 30″ long and 27″ wide with a hood attached (Diagram No. 2). The absorbent cotton produced too much humidity next the skin, and the danger of the infant catching cold was very great. The cord is dressed with a sterile gauze binder and surgical technique is carried out as with other infants. Crede's method is used in the care of the eyes. These are later swabbed with boracic solution when the infant is having his oil rub. Cello wipes take the place of diapers, as they can be easily changed and are absorbent. The infant is placed in his flannel jacket, with the hood fitting snugly about his head. The jacket is pinned at the side and folded up over the infant and pinned at the bottom with small safety pins.



No. 3—Breck feeder.

When feeding premature infants the Breck Feeder (Diagram No. 3) is used in preference to the medicine dropper as the latter permits a considerable amount of air to be swallowed. This induces emesis as the air gets back of the milk in the stomach, and in order to expel the flatus the infant has to vomit his food. The Breck Feeder also conserves the body energy, which is no small item. These infants need to be roused and induced to cry as lustily as possible before each feeding by flipping on the brow or cheek with the finger nail. This improves the circulation generally and the infant progresses much more favourably. When prematures commence to gain they do so more rapidly than ordinary normal infants.

Child Development

By BIRD T. BALDWIN, Ph.D.,
Iowa Child Welfare Research Station, State University of Iowa, Iowa City.

(One of a series of lectures delivered in Toronto and Montreal under the auspices of The Canadian National Committee for Mental Hygiene, in collaboration with the Department of University Extension, University of Toronto and McGill University.)

For generations the problem of the influence of heredity and environment on the development of individuals has been of serious concern to scientists and educators. The problem is still a baffling one, on account of the many factors that contribute to heredity and the extreme complexity of environmental influences. Recently we have heard more about nature and nurture, but these are general terms, not easily defined. Personally, I believe I am beginning to focus the problem more definitely and to see a tangible solution. The problem may be stated thus: What is the relation of capacity to training? We are today in a position to determine with a fair degree of accuracy the capacity of a child at any point in his development from six months to sixteen years of age. We can determine his physical status and probable development, his intelligence rating and probable mental growth. After the age of two or three years we can determine certain phases of motor capacity and motor control; the degree of emotional response as indicated by introversion and extroversion; fairly definite patterns of behaviour in the presence of other children and adults; the size of vocabulary and the use of languages. During school age we can diagnose educational capacities and musical ability. In short, we have developed standardised methods of technique and objective criteria for measuring capacity and subsequent training. And, after all, is not this the aim of education, to develop the capacities and abilities of each individual to the maximum? The important factor is the increase in increment of growth of each individual, based on his initial capacity. Nature furnishes the basis for education, but environment and training are the determining factors in producing the final product.

The personality of a child is a changing, complex, integrated unity. We are just beginning to realise and appreciate the complexity of a child's physical, mental, educational and social make-up. The past decade in education has been one of analysis, and much has been accomplished. Educators and parents are beginning to realise that the essential factor in dealing with a child lies in the unity of his personality. The newer psychology will define the child in terms of objective criteria of behaviour which take into account the combined influences of physical condition, mental development, educational achievement, emotional trends, personality traits, and social attitudes. We are just on the verge of discovering the kind of adult into which a child will probably develop. We can already predict the child's adult physical make-up. With less surety, as yet, we can foretell his adult intellectual capacity. And, in our work with pre-school children, we are discovering early types of emotional and social patterns. We believe that we are finding social reactions among children that give every evidence of being definite forerunners of adult temperamental and social patterns. Please take notice that when I speak of changing temperaments I refer to little children and not to fathers and mothers.

My first interest in child psychology began with the mentally defective, then it centred in adolescence.

But today it is with the pre-school child, for I see the genesis of a majority of problems of adolescence, especially delinquency and social maladjustments, during the ages from one and one-half to six years. These, I believe, are the most important years of childhood.

Normal Child

The extensive work that has been done throughout this country and abroad on defective children during the past decade has helped to clear the ground and to suggest some methods of attack for the fascinating and profitable work on a more basic problem, the so-called normal child. It is, of course, more difficult to see the finer differences among normal children, to note how handicaps and how special defects may be removed and native abilities improved than to observe marked abnormalities among children; but it is decidedly more interesting and more important because with these normal children lies the progress or retrogression of the race. Better children make a better state.

What is a normal child? In a bulletin published by the Federal Bureau of Education in 1914, I stated that the personality of a child is a complex physical and mental unity. For scientific purposes different phases of this personality must be treated more or less independently for analysis, description and explanation, and later synthesized. In the past, scientists have tried to describe an "average child" at a given chronological age, without realising that in so doing the wide individual differences which exist among children destroy or compensate each other. The concept, "average child," is impossible and impractical. A new approach must be formulated which will preserve the intregity of the individual, differentiate special traits, and offer a series of norms or standards for various types from different points of view.

The child's demands are manifold. They are also interdependent; body and mind develop together, while emotional habits and the maturing of the nervous system condition both. Many parents give the child excellent physical care, but take no interest in his intellectual development; others are ambitious for his mental growth, without trying to build a sound physical foundation; still others allow the atmosphere of the home to be strained or unhappy. without realising that the child who thus becomes emotionally unstable cannot develop freely, either mentally, socially or physically.

For purposes of scientific analysis and explanation, every child may be said to have five parallel and interrelated ages: (1) a chronological age in years, months and days, denotive of the temporal span of life; (2) a physiological age, denotive of the stages of physical growth and physical maturity, which is the basic age in growth; (3) a mental age, denotive of the growth of certain mental traits, capacities, interests and abilities; (4) a pedagogical or educational age, denotive of the rate and position in school progress; and (5) a social age and moral age, denotive of the growth of social attitudes and the ability to make, adapt and control social adjustments. These five ages are all present at any chronological age of a child's development. A child may have reached his maximal status in one or more of the four ages, excluding the chronological, and may be retarded in the others. For example, a boy or girl may have normal physical development and be retarded pedagogically, socially or morally, or in any of the other combinations. In a normal child each age is developing at its maximal rate and the physical, mental, educational and social ages nicely balance each other. One need not be neglected as a sacrifice for another.

That the different phases of a child's development are not parallel

with his chronological age can be readily illustrated by a brief analysis of anatomical and physiological growth. We now know, after long study of anthropometric measurements, how children grow in form. We have data that throw light on the relation of anatomical development to physical growth in form. But we need further data on the relation of exercise, diet and environment to anatomical growth. The division of nutrition of the station is working on the important problem of diet in relation to anatomical age and physical growth.

Skeletal Growth

As the best index of skeletal growth we early selected the development of the carpal bones of the wrist and formulated a method of measurement of these bones as shown in x-ray pictures, of which we have about 1,300 of children from birth to seventeen years. The wrist ultimately contains eight small bones which ossify at different ages and at different stages of maturity. Each child has his own anatomical time clock, but there is an approximate average; for example, for the boys, two bones are usually present at three months, at two years a third bone is visible, at four another, at five a fifth, at six a sixth and seventh, and at eleven years the eighth bone appears. With the exception of the first three the ossification of these eight bones occurs one to two years earlier for girls than for boys. The rate of growth of these bones is parallel with growth in height except that the decrease in increment of growth of carpals occurs earlier in adolescence.

The two bones of the arm, the ulna and radius, the five metacarpal bones of the hand, and the fourteen phalanges, or finger bones, are all in ossified form, as a rule, at birth. Distinct caps of epiphyses appear after birth and later fuse with each bone. The girls are at least two years in advance of the boys in both the appearance and fusion of the epiphyses. In the x-rays the little epiphyseal caps stand out prominently in little children; at about fifteen years of age they begin to fuse in the fingers and hand, and at sixteen and eighteen in the two bones of the forearm.

The status of the anatomical growth of the child raises another significant and far-reaching problem on which the station has been working for a considerable period, namely, the physiological age of the child. The problem of physiological age is an important phase of the development of normal children which has received little scientific study. Our results based on eastern city boys and girls, boys and girls from Chicago, Iowa City, and California, and eastern country children show a wide distribution for the one set of physiological functions of adolescence. The range is from nine to seventeen years of age for girls and from eleven to eighteen years for boys, with no particular age including more than forty per cent. of the number of children.

Various investigators in their eager efforts to describe children have arbitrarily divided the life of the child into definite periods; our researches show no marked periods, but a continual overlapping and a gradual transition from one period to another. The progressive stages of physiological development cannot be measured quantitatively like height in inches and weight in pounds. Correlations between the stages that are fairly definite and height, weight, width of hips, and circumference of chest of several hundred mentally gifted children indicate that, for the given age, the taller and heavier children are relatively more matured physiologically than the shorter, lighter weight children.

For the mental growth of the child there are certain principles that are fundamental. One is that the child is most likely to think when he has need. A devoted parent sometimes keeps a child dependent, because he does the thinking for the child. During the

first years of childhood, independence and ingenuity may be developed through play materials. For this purpose, home-made toys and blocks are always desirable since they offer children constructive interests that challenge their abilities and perseverance. Little children who have attended pre-school laboratories or nursery schools require much less care and attention in the home, because they have learned how to play with materials and toys adapted to their stages of mental and physical development. They have learned not only to play, but they have acquired something much more important—how to play with other children and how to invent new games or to modify the content and methods of their play activities.

Pre-School Child

It is now generally recognised that the first six years of a child's life determine in a very large measure his future development and usefulness. A child's mind needs to grow and to be trained during this period of early childhood, just as much as his body. Many very important facts and principles on mental hygiene may be gleaned from the literature of child psychology and from books, pamphlets, and magazines on education and mental hygiene.

During recent years, the pre-school age has been the focus of observation and experimental work in education. At Iowa, the pre-school laboratories were established in 1921. We began with children from two to six years of age, and had a fairly simple programme of determining the capacity of individual children for education from the standpoint of intelligence, emotional trends, social attitudes, language habits, learning, motor control, and physical growth.

At present we have four pre-school laboratories similar to the nursery schools at Toronto and McGill. About one hundred children between twenty months and five years attend daily. Some of the little children who started with us seven years ago are now in the fifth grade of the University Observational School. The purpose of these laboratories is to give the children an opportunity to come into daily and intimate social contact with other children of similar stages of maturity in an environment adapted to child rather than to adult life. Complexity of training, over-stimulation, and pronounced theories of education have been avoided as far as possible. The children come from all classes of city residents; they attend from three to seven hours daily.

From a scientific point of view, our purpose has been to secure suitable material and data for intensive studies of young children, who as a rule are not available for study, under conditions that are so controlled and modifiable that the experiments may be repeated and the children studied consecutively from day to day. The observations and experiments are conducted by members of the staff and graduate students. Members of other divisions and colleges of the university are also carrying out special experiments.

Pre-School Home Laboratory

In our pre-school home laboratory, now in the third year of operation, the children may be from eighteen months to four years; they attend from nine in the morning until three-thirty in the afternoon. This laboratory is designed to be a modern home, based on the best methods of feeding, regular schedules for sleep and play, and training in mental development and child behaviour. A home environment under scientific management offers a new field of investigation in the needs and training of infancy and childhood, especially in the more complicated behaviour problems. The laboratory is in a house of eighteen rooms and a large sleeping porch, with ample grounds and gardens. Here are also located the baby examining laboratory and offices of the child study and parent education division of the station. The aim is to integrate as many sciences as possible from the various departments of the university and to study the child as

a unit; that is, from many angles rather than from a few.

The social adjustments of the child are too liable to be determined only by adults and their activities. With the young child, as I have emphasized on other occasions, personal-control habits of eating, drinking, dressing, sleeping, cleanliness, elimination, and the right attitudes toward regularity are very important from the adult point of view, but are not adequate for the child's development. The basic aim of education should be to furnish a simple but enriched environment adapted to the child's stages of physical and mental growth—an environment in which he can find himself in relation to other children and adults; an environment in which he can develop through daily participation such important personality traits as independence, self-direction, self-control, constructive imagination, creative self-expression, and desirable social attitudes. Many young children develop specialised patterns of behaviour for various environments in which they are placed. These include one pattern for the home, with particular variations for father, mother, grandmother, or aunt, and quite another pattern for the playground or the laboratory school, where other little children of the same stages of development are constant companions.

Another basic phase in the social and emotional development of the child is in learning to relate one's own needs to the needs of others. The child's individuality must be guarded at all costs, but not at the expense of the happiness of others. The best place to learn this is in the home. Many otherwise fine personalities are misfits in society because they have never acqured the habit of merging their own interests with the interests of the larger group. On the other hand, mere conformity to group living is not the goal. It is the attitude which is significant. When the child experiences the pleasure which comes from being a contributing member of a group he has learned something worth while.

Much of what we have learned about children, particularly in the last ten years, has been through the studies of scientists; the responsibilities of parents grow with the growth of scientific knowledge on child development since they must see to it that their children are the beneficiaries of such knowledge. A programme for the ideal development of all children therefore means a programme for the education of all parents. This is the programme that is being carried out in many sections of the United States and Canada.

If there is any subject endowed with national interest it is the welfare of the nation's children. The nation's future existence, the intelligent use of its resources, the role it will play in world affairs depend on its children—whether or not they are physically fit and whether or not they are trained in self-control, in respect for the rights of others, and in understanding of their own rights and obligations. That the first responsibility must rest with the nearest government—the state, the county, and the municipality—is the reason why the role that the Federal Government must play in the training of children is that of an intelligent and interested co-operator, ready to assist but not to control or hamper.—Miss Grace Abbott.

The Education and Service of the Nurse

"In a somewhat perplexed frame of mind, as I have wondered what ordinary practitioners, such as you and I, could do, it has seemed to me that we were comparatively helpless except in one way, and that particular way is this—that we, in our contact with nurses, in every relationship, whether as teachers of nurses in the hospital or as complementary agents with the nurses in the care of the sick, must try to make every nurse feel that she is indeed a part of the broader, wider art and science of medicine; that she is just as important in her own sphere as the doctor is, and to keep her interested in the patient and in the patient's problems by explaining things to her as we go on, explaining incidents of the illness; praising her at times instead of ignoring her, to a certain extent "high-hatting" her, as the expression goes, and making her feel perhaps that her services are not appreciated. I think we are all guilty of that. I haven't the slightest doubt that we are.

"If I may say a word remotely personal, I received a month ago a letter postmarked 'Philadelphia,' which was written in a trembling hand; it looked like the hand of a very elderly person. I opened it and it contained a very large number, perhaps fifty enclosures, slips of paper, and a very brief letter which read: 'Dear Dr. Cheever; I venture to write this to you because I think you will be interested in these mementoes of a member of the profession who has died and whom I revered very much.' It went on to say that the writer was a nurse who had graduated from the Boston City Hospital some forty-five years ago, and had been in the practice of her profession ever since. She said that she had not had a moment's unhappiness in that profession; that she had loved every bit of it; that she was now superannuated and practically retired, pensioned in the family which she had served long and faithfully, and that she was content to realise that her work was about done. The enclosures which she sent were prescriptions, memoranda and notes made by one of the older surgeons who is now dead, which she had preserved. Of course the prescriptions didn't amount to anything in particular, but the notes were memoranda written at the bedside for her guidance in the care of a patient, and every now and then at the bottom of the memorandum for her guidance was written a word or two of commendation of her work the night before. She had preserved them all those years, and it was evident from the manner of her writing that they constituted a part of the intense satisfaction which she felt in her profession.

"If we can, as physicians, have the same relationship with nurses and make only a few nurses, or perhaps one nurse feel that her profession is worthwhile, I think it would do something, at any rate, to solve the problem which we are discussing tonight."

David Cheever, M.D., "New England Journal of Medicine." "The American Journal of Nursing," April, 1929.

A YEAR BOOK

The School of Nursing of the Ontario Hospital, London, has recently published a very attractive Year Book, the first venture of this kind by the school. Beautifully illustrated and containing several excellent contributions, this Year Book amply rewards those who assumed responsibility for its appearance. Elsewhere in this issue is published one of these articles, entitled "Throwing Light on a Dark Subject," which is a timely contribution from a young nurse.

The Call of Eternal Youth

By MABEL E. FINCH, Winnipeg.

May I express to you my appreciation of the great honour you have conferred upon me in inviting me to the Annual Meeting of your Graduate Nurses Association, to bring a message to the young graduates, those whose faces are aglow tonight in anticipation of the new life they are about to enter.

They are imbued with the true spirit of Manitoba, that word whose lyrical Indian meaning is, "The Land of the Great Spirit". Perhaps nowhere is that spirit more fittingly expressed than in the stately grey stone structure that rises in the centre of our capital city, the Legislative Buildings. In majestic dignity they stand, "As a symbol of faith and belief in the future generations of the Great West."

Above the tower and above the dome, in bright relief against the azure sky, is poised the golden bronze figure of a runner. This is the celebrated French sculptor Gardet's conception of the soul of our West, and typifies Eternal Youth, the Spirit of Enterprise.

An incident in connection with this figure may be taken by us as a message of faith in our land. It was cast in a foundry in France about seventy miles from Paris. During the war the foundry was bombed and completely destroyed, this figure alone emerging unharmed from the wreck. Hastily it was rushed to a seaport and put on board a boat bound for America, but before the boat drew out from port it was commandeered for the transport of American troops. For two years the boy lay in the hold of the vessel, travelling back and forth in the war zone, in constant danger of being torpedoed. Finally, the war over, it was landed in New York and shipped to Winnipeg, to become the emblem of our Province.

(An address to the graduates, 1929, Brandon General Hospital School for Nurses.)

Its attitude is that of a runner, indicating that we are not content to stand still. Under his left arm he carries a golden sheaf of wheat, typifying that "Labour provides the means by which man's bounty is obtained". And in his right uplifted hand is a torch, the call of the Spirit of Enterprise to carry the light of education, of health, of high ideals, to the furthermost parts of our province. Who is better fitted to answer that call than the youth of our land?

But before you answer, let us consider a moment what are the requisites to join in this race?

As we look we will note that the face of the runner is turned northward. He who is counted worthy to enter must be able to face unflinchingly, if necessary, the bitter blasts of the Arctic. He, also, who would become a torch-bearer must have vision that reaches far beyond his native haunts—instead of dreary wastes in the Northland he must be able to visualise the great Cambrian region, with its wealth of mineral resources; lakes teeming with fish; forests stretching forth their arms with pulpwood; wilds abounding in valuable furs; mighty rivers latent with power; a port, with industries' ships thronging its waters.

As we listen we can almost hear the words of the poet pass to us from the the lips of the runner:

"Only have vision and bold enterprise,
No task too great for those of unsealed eyes;
The future stands with outstretched hands,
Press on and claim the world's supremacies."

It was vision that over one hundred years ago brought a band of noble adventurers to our most northern port. To them our hearts go out in gratitude for the heritage which we now enjoy. But, you say, are there any today with clarity of vision who have so steadfast a faith? Again we answer, yes, the miners—they who have gone into the Northland and have converted barren

rocks into copper, zinc, lead and gold fields.

Strange as it may seem, these explorers who have answered the call are in many respects typical of the young graduate nurses entering their new fields of endeavour.

1. The essential qualities of a successful miner are courage, faith and devotion. Are these not the very foundation stones of the nurse's success? It is courage that puts backbone into ambition so that instead of a willow wand we are able to enjoy the protection of the sturdy oak. Courage quells storms because it sees through them and beyond them. As Barrie says, "There is nothing else worth speaking about but courage. It is the lovely virtue—the rib of Himself which God sent down to His children. Courage is the thing. All goes if courage goes." With courage go hand in hand faith in yourself and devotion to your profession.

Perhaps no finer exemplification of these virtues is to be found than the life of the late Baroness Mannerheim, whose magnetic personality and ineffable charm won for her the Presidency of the International Council of Nurses. At all times and on all occasions, she had herself in perfect command, and her devotion to her profession was revealed in her all-enveloping love for humanity, which expressed itself in constant self-denying service. To the nurse who would grow in grace and perfection, surely no finer life stands as an inspiration.

2. The second great task that confronts the nurse, as the miner, after adequate preparation, is that of locating. Where shall the claim be staked? This is always a problem, but to you, not confronted with the almost insurmountable difficulties of the miner, for wherever a nurse locates she will find ore, rich enough for development: ore in the form of unenlightened humanity awaiting the touch of the skilled hand to transmute the dull metal into shining gold.

Some of you may answer the call of the Far North literally and learn that the miners' problems are your problems. Fifty miles north-west from The Pas lie the mining centres of the Mandy and Flin Flon, the former with its attractive record of $2,000,000 worth of copper as its output during three years of the War; the latter with its miners' cabins sheltering 200 men and their families. Thirty miles beyond, at Island Falls, another 300 men engaged in power development. Or directly north from The Pas, a distance of forty-five miles, you may travel to the prosperous copper-zinc centre of Sherritt-Gordon, where several hundred people are congregated in log cabins, and where in a few years' time they expect a town of a thousand. All these are busy, stirring little mining centres, composed of motley groups, ranging from the unskilled, unkempt foreign laborer to the highly skilled mechanic and engineer. Possibly nowhere is there greater need of health teaching than in these towns that spring up in the night, people huddled together with no provision for sanitation or health facilities.

Others may turn your eyes toward the seaport of Fort Churchill, where the old world will shortly meet with the new in exchange of merchandise. There, this autumn, will ring out the deafening blows of myriads of hammers, vying with each other in the erection of elevators, warehouses, stores, hotels, restaurants and residences, in the province's model town of Fort Churchill. In due course, as an essential part of that model town there will no doubt be a model hospital, an opening surely for the courageous nurse who loves to watch the stately ships riding on the bosom of the sea in summer, and in winter, to revel in the Arctic stillness, "where silence itself aches with the intensity of winter's frosts".

Other outlying districts there are, too, not so far northward, which call for the missionary type of nurse. Lying between the lakes are numerous scattered settlements of English-speaking people. A few years ago one mother wrote saying, "We are a little English settlement twenty-five miles from a doctor or a nurse, with im-

passable roads almost the entire year. We feel our handicap keenly, especially when some one passes away because of lack of proper medical facilities. Is there any way that you can help us?"

Grouped in clusters between these are numerous foreign settlements, Ukrainians, Poles, Germans, Galicians, many who have had no opportunity for health education in their home land and who face almost the same conditions in our province. True, we have a few heroic nurses in Red Cross nursing outposts, who in addition to their nurses' duties are acting as homemakers, guides and counsellors, the one ray of Canadian idealism among a new people. But, as yet, we are only touching the fringe of the problem. As nurses, the call comes to you. How can you help them?

Coming more closely in, we have our large, well-populated rural areas, some served, others waiting to be served by private and public health nurses. In many of these centres education is beginning to make itself felt and people are realising that health preservation is a process of right living, and therefore an essential part of the education of the home and school. This knowledge has led to the demand for public health nurses as residents of rural communities. Too great appreciation cannot be expressed by the mothers for the service they are rendering in their free baby clinics, in their health teaching in schools, in the instruction given to mothers. But statistics show that Manitoba's maternal death rate is still the highest of any province in the Dominion. The call of Eternal Youth comes to you to save the country's people.

3. Before the precious ore, human lives, can be saved there must be drilling, sinking of shafts, and excavation, and this requires the co-operation of many. As Ruskin says, "We must see each other's and our own problems as jewels, and together work for service to humanity".

Fortunately for the nurse there are individuals and groups in every community who are anxiously awaiting health instruction, such organisations as the United Farm Women of Manitoba and the Women's Institutes. They will gladly co-operate in arranging for courses of health lectures, free baby clinics and addresses at meetings.

To the private nurse in the home comes a special opportunity for service. The anxiety for the one who is ill creates an atmosphere where she can impart health instruction that will never be forgotten. By her words of wisdom she can help hasten the time when the whole province will be adequately served by public health nurses.

4. The opportunity today is for nurses who see the world as their field of service; who regard every life as an inexhaustible mine. True, there may be many lives you will touch that will not appear to be precious. The discovery of the first diamond at Kimberly was made by a child who picked up a pebble on the banks of the Orange River and took it with him into Grahamstown. There Dr. Atherston identified it as an unusually fine specimen of a diamond, and it was sold for $2,500.

Every life is a diamond in the rough. You are the trained, skilled diamond-cutters, who can release the glory of the hidden gem. To you, today, comes the call of Eternal Youth, to join in the race, to be courageous, to have vision, to hold steadfast your faith. Then, in the embers of the dying sun, when you come to look back over your pathway you will find it strewn with diamonds. Some sparkling with ruddy, ruby lights: the mothers, whose lives you have been the means of preserving to their little ones. Some shedding forth a soft amber luster: those who have been saved by you from years of illness and are quietly endeavouring to follow your health precepts. Some sending forth blue and violet rays: those who will end their lives on beds of suffering but whose pain has been relieved by your tenderness. Some resplendent in their pure, white iridescence: those lives to whom your coming has brought a new vision who have been purified by your presence.

This is the reward of those who are faithful. These are the gems in the nurse's diadem.

Reduction in Cancer Mortality

The International Cancer Conference convoked by the representatives of the British Empire Cancer Campaign between July 16th and 20th, 1928, gave an opportunity for the discussion, among other subjects, of the best means to detect malignant growths early and cure them completely. Speakers from many countries pooled their knowledge in this field, and the result was a remarkably unanimous consensus of opinion. It was generally agreed that *early* diagnosis followed by *early* and skilled treatment offer very good chances of a complete cure. We may here quote one of many facts—not theories, hypotheses, hopes or speculations — giving incontestable proof of the benefits of early diagnosis and treatment. In the town of Leeds, an analysis of the cases of cancer of the breast operated on before the growth had spread beyond the breast, showed that 90 per cent. had had no recurrence ten years later and were presumably cured.

Some striking figures concerning cancer were given by Sir John Robertson in Birmingham, where over 1,200 deaths from this disease occur annually. In the case of deaths from cancer of the breast, the average interval between the detection by the patient of a lump in her breast and seeking medical advice was ten months. The pity of it! He concluded: "We have learned in recent years that early removal gives a fair chance of cure in cancer. The problem, therefore, seems to me to be one of educating the public as we did in the case of tuberculosis to apply at once if any doubt arises in the mind."

In the past, the diagnosis of cancer has been considered as synonymous with a death-warrant. Now, figures, such as those quoted from Leeds, show that when the disease is in an accessible position and is treated early, it is curable. The problem resolves itself then into a search for means to assure early diagnosis and early treatment.

In this connection many roads leading to the same goal have been explored or projected. One of them was discussed by Dr. A. Cook, of Cambridge. As he pointed out, 5,290 women die of cancer of the breast every year in England and Wales—roughly twice as many as die of appendicitis. He considered that the only possible means of early discovery is by routine examination at a breast clinic once a year. In a town of 100,000 inhabitants, this plan would mean that about eighty women would be examined every day during 250 working days in the year.

One of the most interesting and encouraging contributions to the discussion was made by Dr. George A. Soper of New York, who described the work of the American Society for the Control of Cancer during the past fifteen years. By every means known to official and voluntary health agencies, it has put authentic information about cancer before the public. Short periods of intensive health educational activity, known as "Cancer Weeks," have been the means of teaching thousands the elements of cancer. On one occasion a "Week" was held simultaneously in all parts of the United States; on another, the campaign was taken up in one part of the country after another in accordance with a prearranged schedule. An idea of the magnitude of the audience reached may be given by the fact that, in November, 1927, a series of sixteen educational articles was published by over 500 newspapers in the United

States with an aggregate circulation of over 10,400,000 copies a day. Allowing four readers to each copy, this information was placed in the hands of about 41,000,000 people every day for over two weeks.

What has been the result of all this educational work? Dr. Soper said: "Physicians are making their diagnosis and aplying the treatment required more promptly. Figures supplied by the Pennsylvania Cancer Commission in 1923, based on investigations made in that state thirteen years apart, have shown that the educational work has cut down the period between the discovery of the first symptoms in superficial cancer and the first call on the doctor 20 per cent., and in cases of deep-seated cancer nearly 50 per cent. The delay due to the doctor has also been reduced. The time between first consulting the physician and the operation has been reduced about 65 per cent. in superficial cancer, and in deep-seated cancer 67 per cent. Evidence from other parts of the United States has, in general, confirmed these results."

It will be observed that Dr. Soper referred to two distinct phases in the career of the patient suffering from cancer: the first phase lasting from the appearance of the first signs of cancer to the first medical examination, the second lasting from this examination till expert treatment is started. To shorten the first phase is a matter of educating the public. To shorten the second phase, doctors must keep their knowledge of cancer up-to-date. This was a point on which Professor Blumenthal of Berlin insisted most emphatically. But of what use is it for a general practitioner to know what to do with his patient at once if she does not come to him till the disease has advanced to the inoperable stage?

To do so, certain elementary rules must be followed. Dr. W. Allen Daley of Hull has described them in detail. His equipment includes the short leaflet in plain, popular language, notices in the press, public lectures, health exhibits, posters, films. Sporadic efforts are not enough. In this matter, as in most other important undertakings, an organisation which provides for a complete and well-sustained campaign is essential.

In every community and in opposition to every movement, however laudable, there are always to be found critics anxious to put a spoke in the wheel of enterprising pioneers. The education of the public about cancer is no exception to this rule. The opponents of an educational campaign would smother it by insisting that educational campaigns degenerate into scare-mongering and result in outbreaks of cancerphobia and neurasthenia. But however carefully this criticism is examined, it is impossible to find more than two classes of persons concerned: those who are and those who are not suffering from early cancer. The first would surely benefit from advice, which would lead them to an early medical examination. As for the remainder, they would, if alarmed, in most cases consult a doctor and in due course be reassured. As has been very aptly said by Sir Berkeley Moynihan, "if you do your educational work properly, you do not, indeed, frighten them to death, but you frighten them to life."

(From the Secretariat of the League of Red Cross Societies.)

Department of Private Duty Nursing

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Constipation: Its Cause and Correction

By Dr. N. A. PAGE, Department of Internal Medicine, Lockwood Clinic, Toronto

There are few, if any, better definitions of constipation than that given by Ludwig Kast, in which he has expressed himself thus: "Constipation is a disturbance of intestinal function characterised by the insufficient or abnormally retarded elimination of intestinal contents." It is my intention to deal only with the so-called functional constipation, though it should always be remembered that careful consideration should first be given to determine whether or not the case in point is a member of this large group, or whether actual disease underlies the condition. If any doubt remains in the mind of the doctor, any organic diseases of the type of cholecystitis or chronic appendicitis, should be eliminated. Failing this, proctoscopic examination should be made and complete x-ray pictures be taken of the stomach, small bowel and colon.

The question of the importance of this symptom to the welfare of the patient next arises. Here we find a great diversity of opinion among authorities. Some claim that it is of the utmost importance, since it underlies so-called auto-intoxication, which is popularly referred to by patients as "poisons" in the system; others believe that it bears directly on increased blood pressure without kidney or other demonstrable disease; while still others associate it with low blood pressure. There are those, on the other hand, who think that unless constipation occurs to a degree of severity approaching obstipation, it has little, if any, significance. Whatever one's opinion on the subject may be, the question cannot be disputed that, in the mind of the layman, constipation assumes a most important role. Our daily newspapers are filled with advertisements for various patent preparations alleged to relieve or cure the condition. This indicates the position it occupies in the mind of the public. And, since we are, in a sense, the servants of the public, it is our duty to endeavour to deal with the condition intelligently.

Out of three hundred consecutive cases reviewed there were found to be one hundred and twenty-six who gave constipation as one of their complaints, that is, forty-two per cent. In addition to these, there were thirty-seven who, on being questioned, stated that they had had some trouble in this regard for many years. Thus, if such are included in our figures, the percentage is raised to fifty-four.

Diagnosis

In diagnosing constipation, the first essential is to ascertain whether or not the patient is truly constipated. Indication of this is found in the stools. The truly constipated will give a history of passing hard, dry faeces. Many patients are found who believe themselves to be suffering from this condition, who, on being questioned, report the stools as of normal consistency. This is not true constipation, since, if there is a delay in the passage of the food residue in any section of the intestinal tract, fluid content must be lost, with the result noted. A more accurate estimation may be arrived at by the administration of carmine, given in ten-grain capsules; the evidence of the excretion of this dye will occur in the normal individual within twenty-four to forty-eight hours and will be complete in seventy-two hours.

The old classification, spastic, when the bowel is in a state of increased muscular tone, and atonic, when there

(Canadian Medical Association Journal, November, 1928, with slight revision by author.)

is an associated flaccidity, is discarded by Erdheim, though it would seem that it is still of service, if one remembers that there may be, in the one patient, a combination of the two types, and that each large division is again subdivided into several branches.

Either type may be most accurately and readily diagnosed by x-ray methods; the atonic being shown by the large, somewhat relaxed colon with deepened haustra; the spastic by the small, constricted bowel. Irregularities, however, may occur, with relaxation in one part followed by constriction without organic obstruction in another. This will complicate the picture and the treatment. It is neither desirable nor necessary to submit all patients to this expensive mode of diagnosing their condition. If, however, any possibility of organic disease exists, it is perhaps not out of place for us to stress again the importance of these measures.

The spastic type is usually found in the highly strung, so-called neurotic, individual, and in the great majority of these, the sigmoid colon, and sometimes even the entire colon, may resemble on palpation a firm rope-like mass which is invariably tender. The atonic type, on the other hand, is usually found in the otherwise healthy individual, or in those of the lethargic type often living a too sedentary existence. The colon of such is neither palpable nor tender. Boborygmus is often noted and there is usually a lack of tone in the abdominal muscles, with a resulting visceroptosis, that is, the organs lying at a lower level than is their usual site. One is too prone, however, to diagnose visceroptosis as the cause of the associated constipation. Ludwig Kast feels that such is never the case, though it may occasionally be an irritating factor. Even radiologists now hesitate to consider displaced or slightly kinked colons to be of great importance without signs of associated disease producing this abnormality.

Rectal constipation is often allotted a separate classification, though it is actually an atonic form, readily diagnosed by complete rectal examination, the rectum being found lax, distended, and usually full of hard, faecal masses. This may be caused by repeated enemata; by the presence of haemorrhoids, with resulting pain without defecation and consequent suppression of the act, first conscious and finally sub-conscious; or it may be predisposed by a congenital tightness of the muscle closing the anus.

Before dealing with the cases under consideration one might mention the possible complications of any one of these three forms. Colitis may result from damage to the intestinal wall, this alternating with constipation, though in such cases malignancy must be watched for particularly. Fissura in ano, pruritis ani, and haemorrhoids must be added to the list. When one remembers that actual ulcerations may in turn serve as a focus which may act like other foci in the body, such as teeth and tonsils (though showing an apparent preference for the abdominal organs, the gall-bladder, appendix, kidneys, etc.), one is impressed still further with the importance of this subject, which is too often lightly dismissed by many of us.

Etiology

Considering in somewhat greater detail the etiology of constipation, there are numerous factors to be considered, many of which are the direct result of our civilisation. Even in prehistoric days when, in the process of development, man assumed the upright posture, gravity was given a greater chance to favour ptosis. This was further aided in a later stage of our existence by the increasing sedentary nature of our lives. But, as before explained, many patients with a marked degree of visceroptosis enjoy normal evacuations, and so this must be considered as only one possible link in the chain. In women, pregnancy would seem to produce an increased tendency to this complaint. Here, three factors may play a part: first, the general laxity and resultant weakness of the abdominal musculature; secondly, the common occurrence of haemorrhoids at the time of, and preceding, labour,

with the resultant tenesmus and subconscious suppression of desire; and, thirdly, the mechanical interference during the middle and latter months, with subsequent habit formation. Lack of exercise, too, plays a part, though it is questionable if it is so great a factor as is popularly believed. Patients in hospital may be controlled without catharsis by a rational diet-combination of carbohydrates and fats. It is claimed, on the other hand, that postmen and policemen are inclined to constipation. Since none of such is included in our series we cannot contribute any figures on this point. However, we do find many farmers suffering from constipation. Their diet, as a rule, is adequate and wholesome, somewhat rough in type, supplying, one would think, sufficient volume and residue; nor is there any lack of exercise in their lives. But, on investigating their history further, we find that on leaving the house in the morning they often spend the entire forenoon in the fields, and on their return the optimum time for evacuation has passed. This might likewise apply to postmen and policemen.

The drinking of water is also of importance, though experience does not lead us to believe it to have so marked an effect on the bowel as is generally supposed. It is, without question, an excellent diuretic, and serves its part in carrying away the waste products of metabolism; but few cases of constipation are cured by its use. A glass of hot water, taken on rising, may serve to stimulate intestinal peristalsis; following this, the morning meal adds its effect, and the after-breakfast habit is in this way influenced by the morning draught.

It is claimed that blood pressure has relation to constipation. Alferez, however, in reporting one thousand cases of essential hypertension, finds that only forty-six per cent. give this symptom, this being no higher than the percentage found in this clinic of all patients. Low blood-pressure, likewise, has little demonstrable relationship to constipation. Only thirty-nine per cent. of the cases here reported showed a systolic blood pressure of less than one hundred and fifteen, thus leaving the great majority of patients well within the normal range.

Sex, also, seems to be of importance, since forty-six per cent. females, compared with thirty-seven per cent. males, complained of constipation. No doubt the difference is explained, to some extent at least, by the process of child-bearing and labour.

Age, too, is a contributing factor, due in part to a changed manner of living, but principally to the physical changes that are undergone with the advance of years, the weakening of the musculature, and the general loss in elasticity of the body tissue. Unfortunately, our group does not illustrate this point, as the majority of these patients varied in age from twenty-five to fifty-five years of age.

Some members of the medical profession feel that the endocrine glands play an important part, their secretions acting directly through the nervous mechanism. Of these, the pituitary and the thyroid seem to be the most important, and though at this time the study of glands is in its infancy, and the tendency is to find in these the hypothetical source of any trouble of which the true nature is veiled in obscurity, yet we are forced to admit the possibility of this influence. All cases of intestinal stasis do not show signs of glandular hypofunction, but one rarely finds a patient giving evidence of hypothyroidism, by lowered basal metabolism, slow pulse, low blood pressure, etc., who does not include in his list of complaints faulty evacuation of the bowel. It is also true that such patients respond marvellously to treatment directed along these lines. the administration of the glandular extract often being in itself sufficient to control the condition after the preliminary restoration of normal function.

The last factor to be considered is one of the greatest, if not the greatest contributing cause of constipation, that is, the practice of habitual catharsis. Mothers, anxious for the

welfare of their children, start the regular administration of pills, castor oil, salts and similar laxatives at an early age. In many cases it is a hard-and-fast rule that Friday night is the regular time for such medications, entirely unmindful of any need for such measures. Thus, the habit is established in the young, and too often, as time passes, it apparently becomes a necessity. Cathartics are perhaps among the most constipating medications that one can take, and should be used only as emergency measures. The same remark applies to enemata. This practice is fortunately not so widely indulged in Canada as in many parts of the United States. Enemata have their purpose, but to educate people to believe that they require "internal baths," as they are called by their ardent supporters, as frequently as they require external bathing, is absolute folly.

Symptomatology

Discussing the symptomatology of stasis with any degree of accuracy is a matter of some difficulty, and yet there is a certain sameness that occurs with persistence in such cases, making it safe to assume that there is a definite relationship between these common features and constipation. Such are: a history of fullness after meals; belching of gas a variable time after food; vague abdominal discomfort; often dull, aching pain in the lower left quadrant; sometimes a similar discomfort in the right lower quadrant, suggesting on examination chronic appendicitis, though no history of an acute attack is obtained. Headaches are common. Anorexia, foul breath, coated tongue, occasional nausea, are complained of, and sometimes regurgitation of food after meals. Abdominal cramps, gas within the bowel, pain in the back, etc., may be added to this list. In practically all cases where the gastric acidity is normal and there is no associated organic disease, these symptoms greatly improve or disappear with proper control of the bowels.

The complaints generally associated with constipation, such as tiring readily, exhaustion, nervousness, lack of reserve energy, dizziness, palpitation, etc., are not, however, so amenable to treatment. Constipation is almost invariably found associated with migraine, and is also present in the majority of cases of epilepsy. When the normal intestinal function is restored there is usually some improvement in the symptom complex, but as it can be classed only as an improvement, one is forced to conclude that it is but one of several factors at work.

Treatment

And now, in conclusion, a word must be said as to treatment. No set rules can be applied as a routine, since the procedure to be adopted must of necessity vary materially with the type and with the cause in each individual case. We have indicated certain measures throughout. Unquestionably, a normal healthy life is essential, paying particular attention to the regularity of one's habits, to meals and hours of sleep. A glass of water on rising has certain benefits, the mechanism of which we previously explained. The time for going to stool should be definite, and the optimum is, without doubt, immediately following the morning meal. The position at the stool is important, the knees well flexed on the abdomen. The diet is most essential. There are few patients with functional constipation who will not in time be able to carry on normally on a diet rich in carbohydrates such as fresh and stewed fruits, figs, prunes, green vegetables, sugar, etc. Roughage may be obtained through whole wheat bread, bran muffins, etc. As a rule, tea, cheese and excessive meat-eating should be avoided. Excesses of fatty foods should likewise be eliminated, though it is interesting to note in this regard that Florence H. Smith reports excellent results in the treatment of constipation by high fat feedings. Her prescribed diet consists in protein 66, carbohydrates 164, fat 224, which she states will control even the most persistent cases in three to five days, though she reports that a very occasional patient has resisted treat-

ment for as long as three months. Psyllium seeds, flax seeds, bran, etc., are of marked benefit in many cases, supplying the necessary bulk for stimulation of peristalsis. Yet, these should be introduced with care in the case of patients who have been on soft bland diet for long periods, as they may by this sudden radical change be markedly upset, and the co-operation and confidence of the patient is lost before treatment is well inaugurated. Cathartics, enemas, etc., should be discontinued, though in the most obstinate cases it is impossible to suddenly accomplish this. A little cascara may be given primarily, but the importance of gradually diminishing this cannot be over-stressed. Small retention oil enemas are often useful in the presence of hard, impacted faeces, such as are found in rectal constipation. Soap-suds enemas of the usual type should only be used when absolutely necessary.

Massage, while used by many, does not find a supporter in Soper. The purpose of this massage is to stimulate peristalsis. It is questionable if it accomplishes this, and undoubtedly the intake of food forms a much more reliable stimulant. It is, however, still employed by many physicians, the massage following the lines of the colon and being of a gentle rotary nature. Even by this procedure, there have been several cases reported in which damage to underlying diseased organs has resulted. However, we are presupposing that such disease has already been carefully eliminated.

Mineral oil is our greatest ally in combating constipation, being second only to dietetic measures. This, too, however, has its disadvantages, producing at times a seepage from the rectum which is found embarrassing to the patient. Fortunately, however, in its emulsified form this disadvantage is largely overcome, and we have in many cases found it of the greatest value combined with the old-time remedy, agar-agar. Several patients have recently asked whether there is any danger in the use of mineral oil as a causative factor in the production of cancer. This idea must have been obtained from some published article, but we are unsuccessful in finding anything dealing with this subject. Perhaps the idea arose from a paper by Robert Gibson in which he pointed out that seepage may produce an eczema about the anus which might in time assume a cancerous nature. However, he cited no case in which it had done so, and, as the seepage may be controlled by the use of the emulsion, it would seem safe to overlook this theory as a possible contra-indication until more material evidence is produced to support it.

In conclusion, certain drugs may prove useful in chosen cases. Belladonna is an excellent adjunct to the treatment of the spastic type; similarly, bromides and luminal are found to have a favourable effect on the psycho-neurotic patient; pituitrin is useful in those giving signs of atonic constipation; thyroid extract, which we merely mention, having dealt with it previously; and olive oil, which is useful in the under-nourished type, in the absence of any suggestion of an associated cholesyctitis.

Throwing Light on a Dark Subject

By CATHARINE HOWARD, Class '31, Ontario Hospital, London

Schools for nurses in general hospitals have yet to realise the importance of psychiatry. They have not yet sensed their responsibility in regard to this branch of nursing service.

We understand that at one time general hospitals were for the treatment of physical diseases only. The majority of them still are, and there is no doubt it is a task in itself large enough for any hospital to undertake.

But some instruction in psychiatry to the nurses in these hospitals would result in a more sympathetic attitude towards all types of patients, and unquestionably be of service to them in their care of an emergency mental case.

Take the case of a patient admitted to a general hospital suffering from a severe physical illness, which is invariably accompanied by much distress and anxiety, and, without warning, marked mental characteristics develop.

This catastrophe, unlooked for and unexpected, changes the patient immediately into a personality so different that only the experienced psychiatrist can attempt to analyse the obscure phenomena of the patient's mind. A gulf deep and wide soon opens up between the patient and those in attendance on him.

The utter futility of trying to carry on without the co-operation of the patient is realised, and as soon as possible he is transferred to a hospital for mental diseases.

In our junior year we are instructed in elementary psychiatry, in our intermediate year we are given advanced psychiatry, and even in our junior year this study enables us to see that our most important therapy is to endeavour to procure for the patient some peace of mind.

This was the foundation of all Greek medicine, and today it is the leading measure in our therapeutics.

The specific treatment, applicable to the type of the mental disorder, is next considered. Today there are many new and different methods of care and treatment from those of a few years ago, and the present trend of progress predicts a hopeful future.

The amount of ignorance and misunderstanding that surrounds the mentally ill is amazing. It can be dispelled by nothing but some knowledge of psychiatry. For any intelligent person, with an honest desire to know something about it, there are many good books dealing with the subject in simple and readable form.

PHOTOGRAPHS UNDELIVERED

Information has been received that a number of photographs of the Grand Council, International Council of Nurses, taken at Ottawa, on July 3rd, have not been delivered. Any nurse who placed an order with Menzies, photographer, for this photograph and who has not received a copy is requested to notify Miss Gertrude Garvin, Strathcona Hospital, Ottawa. Miss Garvin has kindly offered to assist in adjusting any reports of non-deliveries.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

Co-Relating Health Education in a City Secondary School

By Miss K. E. DOWLER, Daniel McIntyre Collegiate Institute, Winnipeg.

The following is a brief report upon an experiment made in co-relating health education in a city secondary school.

The experiment in question has extended over nine years and deals with the health education as taught with the regular programme in Domestic Science to the girls coming to one centre weekly from Grades 8 to 10 inclusive. The ages range from 11 to 18 inclusive; and since September, 1921, over 1,600 girls have been reached in this one department.

Domestic Science, because of its very nature, offers perhaps more co-relatives with health than almost any single subject, but we have selected from the programme followed those projects which could be carried out in almost any class room. We might add that the cost in this particular programme has only been the cost of the material for wall charts and the class room scales. The reward for such labour as it involved has been entirely in the response of the children in sustained interest, in the splendid evidences of health improvement, in weight, in appearance, class standing; and the gain toward the close of each year in cheerfulness, improved discipline and happiness.

Outline of Administration in Health Education in Domestic Science Classes

1. Each student is weighed and measured to find departure from the average weight for height and age. (The Wood tables were used first, and for the last three years the Baldwin Wood height, weight, age tables.) Ten per cent. below average and over 20 per cent. above average are considered the danger points.

2. Signs of positive health are taught to each student and looked for in herself and others. These signs are evidenced in condition of weight, posture, muscular development, appearance, freedom from physical defects, etc.

3. All students are encouraged to try to reach the best weight for build. Weight in relation to build is the best criterion, as it is difficult to standardise, and for average person to judge.

4. Students are reseated according to departure in per cent. from average weight for height and age. This makes four groups for comparison in progress and for relating definite health instruction.

(1) Those more than 20% above average on "Over Weight Heights."

(2) Those safely above average weight on "Safety Hill."

(3) Those less than 10% below average weight on "Underweight Slopes."

(4) Those more than 10% below average weight in "Danger Valley." These last may be classed as definitely undernourished.

5. Members of class are urged to seek medical examination in order to find out whether they are free from physical defects and therefore, "free to gain."

6. Health officers are elected by each class to aid in administration, class initiative and record and chart keeping.

7. Health rules for daily practice are selected to suit class needs, particularly overweight and underweight conditions. It is well to have each student list her individual needs.

8. Health rule records are marked daily in a small book. These are

checked each week by the owner, and each term by the health officer or teacher. A comparison of records is made weekly.

9. Regular weighing is done once in four weeks, and measuring once or twice yearly. Records are kept and the health officers assist in the clerical duties.

10. A weight chart or graph of weight progress is made in each note book, followed by one on a large scale for blackboard use. (These could even be improvised out of wrapping paper.) Class room charts and individual weight cards may be obtained from the Department of Health and Public Welfare.

11. Health talks are given by the teacher whenever the subject or time permits it.

12. Books, magazines, pamphlets and advertisements are searched by teacher and class for health material.

13. Health posters are made, using coloured cut-outs from magazines, etc., to illustrate truths. The printing is done either by hand or with a printing set. Marks are given for this work.

14. Testimonials are written upon the subject of—"What Health Rules Have Done for Me," etc.

15. Comparisons are made between health progress and progress in individual standing in class.

16. Every food lesson is a practical health lesson. Therefore, there are numerous co-relatives between: Health and diet, diet and disease, adequate breakfasts, and lunches, etc. Feeding for various ages in health and disease. Sanitary preparation of food; and disposal of waste, etc. Means of rest, work, play, eating, drinking and bathing that are most conducive to good health.

The closing exercises each year are planned to show parents and friends the results of work in health education along with results of regular class room work.

Here are some extracts from the health testimonials of the students:

"The girls all seem brighter in class work because the first twelve in class standing are all girls. The boys in this room have not had a chance to learn the rules of the game."

Testifying to improvements in health and disposition, etc.

"I have not had a bad cold all winter. After starting the health rules I felt fine and was very happy. I used to have a very bad temper, if any one asked me anything I would not answer them properly."

"Health rules have made me more lively. I have had a perfect score fourteen times and gained nine and three-quarter pounds in six months."

From a girl above average weight: "I feel much better, and am more interested in sports."

"I never feel tired in the morning any more. My mother does not know what to think of me. I never wanted to do the dishes, but now I jump up as soon as everyone is finished and do them right away."

"I will always keep my health rules if I can, and I hope always to feel as well as I do now. It is not a hard thing to keep health rules, but a good and jolly game. I feel much better and less nervous since trying to keep the rules faithfully. I have made a good gain in weight."

"At first when I was told about health rules I thought it would be a very tiresome business, but now I find it very interesting and delightful to keep a record of what I eat and how much I sleep each day, etc."

"I was a girl who had no colour, and what colour I had, I had to put on myself. One day when Miss D——, was weighing me she said, 'Eileen, why don't you try to paint your cheeks from the inside?' On my way home from school I was thinking it would be great to have cheeks with natural colour. Health rules have put roses into my cheeks and I smile a lot more."

In closing may I add, that wherever you are, I wish you success and invite your co-operation in this good cause, which will mean more happiness for all concerned.

("The Western School Journal," June, 1929).

The School Teacher's Health

The schoolmaster has changed much of late and the schoolmistress more. On the whole, conditions are much improved in those countries which can afford to pay teachers properly, and which realise that money spent on educating children well is one of the very best possible investments. Better pay for teachers means that a better class of person, physically and mentally, is attracted to this profession, and that throughout their professional careers, teachers can take better care of their health and keep their own education more up to date than hitherto. But though the lot of the teacher has been greatly improved of late in some countries, we have certainly not yet reached the stage at which we can placidly and contentedly claim that all is well and further reforms will only spoil the teacher.

Dr. Arnold, of Rugby, used to say that the day he could no longer run upstairs, he would feel it his duty to retire. It would merely be a rhetorical gesture to ask what proportion of present-day teachers could pass this test; but it will be instructive to study the observations of doctors and others who are most closely concerned with the health of teachers of both sexes. In this connection there are three studies of exceptional interest, one by Professor Frank Smith, one by Mr. J. Y. Hart, and one by Dr. Letitia Fairfield. These studies not only show the actual losses from ill-health among teachers, but they also indicate the lines to be followed if the health of the teacher is to be improved. Dr. Fairfield's study was based on a series of 900 consecutive cases of schoolmistresses referred to the school medical officer on account of absence for over a month, and for sundry other reasons. The number of teachers concerned was 13,748, and the period over which her observations were made was 12 years.

The schoolmistress, it would seem, is much more subject to ill health than the schoolmaster. The average illness of men teachers in elementary schools in London in the period 1904-1919 was 4.6 days a year, whereas, for single women it was 8.2, and for married women 9.3 days. Here is a very extraordinary state of affairs. Whereas the death-rate in England at all ages except the age 10-15 years is higher for the male than for the female, the sickness-rate of teachers is about twice as high in women as in men. In some paradoxical way it would seem that women save themselves from death by becoming ill! But there is no doubt that the comparatively high morbidity rate among schoolmistresses should be carefully studied with a view to its reduction. Dr. Fairfield gives some useful hints which both the employer and the employed would do well to note.

Among the series of 900 cases already referred to, cases of anaemia and debility figured prominently among the schoolmistresses who were absent for short intervals. Some of the causes would seem to be lack of exercise, fresh air and sunshine in town-dwellers, and too long a journey to work. Women who are tired by the long daily journey may keep fitter if they live nearer their work and get what fresh country air they can at week-ends. An excellent piece of advice with regard to food is "to be intelligently omnivorous and not to fuss." A hot, fairly substantial midday meal is to be preferred to the sardines and cheap pastry which in the past have been chosen on grounds of economy; they are not the choice of a sound instinct or of a scientific knowledge of physiology.

Many chapters could be written on the dietary of business women, but the principles involved are perfectly simple. Given the money wherewith to buy food, and time enough in which to eat it at leisure, women can be trusted to cater rationally for themselves, always provided that there is not some poor relative or an inordinate craving for finery to absorb the money which should be ear-marked for food. Such unwise diversion of funds is, no doubt, one of the considerations which have induced certain large firms to feed all their employees on the premises at an inclusive rate. For better or worse, this arrangement is seldom applicable to the school-teacher.

Laryngitis, it would seem, is being reduced because voice production is carefully taught at college; but a new cause of laryngitis among schoolmistresses is excessive cigarette smoking. The modern woman cannot be denied her cigarette; to forbid it wholesale would require more than leonine courage. But it may be gently intimated to heavy smokers who suffer from laryngitis that relief therefrom is largely a matter of self-discipline. Noisy, dusty and draughty rooms are also important causes of laryngitis, and so are septic tonsils, the removal of which may often prove salutary.

Chronic indigestion and dyspepsia are fortunately on the wane among teachers. The tennis-playing, dancing woman of today has a much better chance to avoid indigestion, constipation and various other digestive troubles than her pink-nosed predecessor with her bottle of bismuth mixture and her flow of confidences about her stomach troubles. The abolition, or at any rate the evolution, of the corset may also partly account for some of the improvement of women's health. It is not for mere man to speculate as to what will be the decision of woman when and if she has in the future to choose between good health and a corset which sacrifices it to the dictates of fashion.

There is another cause of ill-health, of nervous exhaustion among teachers. It is the large class. It has often been argued that the class of 30 is twice as expensive as the class of 60. The matter is certainly not so simple, and it is probable that the large class is the direct cause of much ill-health among teachers, as well as being a serious menace to the vitality of a school. Mr. Hart found that nervous and mental conditions were responsible for 12.8 per cent. of the total absence on sick leave among men teachers, for 17.4 per cent. among single women teachers, and for 17.2 per cent. among married women teachers. Hysteria may now be considered comparatively rare, but neurasthenia has become most common, and so have anxiety neuroses. The sufferings of this class of patient do not end with herself; she may spread misery around her, and fairness to all concerned demands that no step should be neglected which can prevent or mitigate nervous ailments among teachers. Let us hope that the school authorities will do all they can to reduce to a minimum this disability which inflicts such incalculable suffering on both teachers and pupils.

(From the Secretariat of the League of Red Cross Societies.)

A True Story

(Contributed)

The various problems which face a Child Welfare nurse daily, would never be suspected by the man in the street, as she goes along neatly dressed in her grey uniform, walking briskly through the numerous streets of her district, climbing the more numerous stairs that "ornate" our city.

Her chief work is the welfare of the baby, but there are so many reasons why this welfare is at stake, that it would be difficult for the nurse to limit herself to the routine of the work. The town of X——, is growing, so everybody says: is it possible that one particular district cannot benefit from this actual phase of progress? Would you believe that in the year 1929 there are babies living, babies arriving in hovels, where space, comfort, mere cleanliness are utterly unknown.

Let us accompany the nurse and enter into one of them. From the baby's chart, we have already some suspicions of what we are about to witness: a mother has brought her child to the previous conference for the first time and the result of the complete physical examination by the Health Centre doctor is particularly significant—Nutrition: poor; Rickets: yes; Skin: unclean; questioned by the nurse at the centre, the mother admitted that she gives a proprietary food. "It is cheaper, nurse, when one can't buy milk or ice." Many children? "Eight, but five dead."

The nurse has given us this information "en route"; meanwhile, we observe the narrow and stuffy streets, the garbage containers of every description opened to starved cats and dogs surrounding the locality; the small grocery stores where the children are sent to buy unreliable milk and pastry half eaten by rats. A few timely remarks divert our thoughts; she is swiftly but quietly making her way through a back yard "hemmed in" by eighteen hovels inhabited by families averaging five members each. A stable nearby completes this picture, and a white horse comes to greet us in a friendly way: it seems as though horses, cats and famished dogs are the only friends of these unfortunate people.

One of the children playing in a pool of stagnant water, runs ahead of us toward the shack and hails proudly: "Maw, the nurse!" We are invited in by a tired and anaemic looking mother; with one corner of her apron she dusts her only two chairs, murmuring an apology for the appearance of the room. This is washing day. A pile of rags, which can hardly cover a human being, lies on the floor; we look interrogatively at the nurse. Later, we learn that these rags come from the dump; it is a usual procedure in the locality to hunt up discarded mattresses, pillows, clothes, etc., etc., which are brought home by the father, while the little ones carry the lighter loads.

The following dialogue takes place between the nurse and the mother: "How are you, Mrs. Bland?" "Oh, not too bad, nurse, but me legs and me back is sore these days." "Did you go to the prenatal clinic as I advised you?" "Yes nurse, and the doctor wants me to drink one quart of milk daily, lots of fresh vegetables, and to rest as much as possible; the nurse there was kind enough to give me a paper for a place called the Diet Dispensary, and I have had better food since, but I can't rest much."

"Mrs. Bland, could you put your little ones out to play and try to rest in the daytime?" "I'll try, nurse, I'll try." "Where is your baby, Mrs. Bland?" "Come and see him, I did not wash him today, but he sleeps fine."

Adjoining the kitchen, is the bedroom. Two rooms compose this hovel: a big rusty stove, a small table, two

broken chairs, a double bed, a cheap dresser with drawers minus their handles, and two cots are the earthly possessions of this family.

The baby slept more or less, in the darkened room, swarmed with flies attracted by a soother pinned on the child's breast, as well as by the milk bottle half filled and lying aside on a blanket of doubtful cleanliness.

"Why do you not put the baby out to sleep, Mrs. Bland?" asked the nurse, "don't you think he would be more comfortable?" "I'd love to, nurse, but the neighbours' children play awfully rough and baby might be hit by a stone."

"At least, could you not use a netting in the window, to protect him against the flies; the flies are as deadly as stones." "You see, nurse, my man is not working steady at the plant, he works off and on, and it costs a lot to pay for the rent, the food, etc., etc." "Has your husband learned a trade?" "No nurse, he left school at fourteen, had to work, could not learn any."

"And yourself, Mrs. Bland, do you cook and sew well?" "Nobody showed me, nurse, me mother died when I was twelve, I do the best I can."

"Now, Mrs. Bland, your baby is awake, let us see him, please."

The mother exhibits a pitiful sample of humanity: eleven months and visibly an idiot. Moved by a maternal intuition, the mother inquires with a worried expression: "Why is it, nurse, that my baby is not like the others, he does not grab at anything, he does not hold his head erect, he does not even stand?" A tactful conversation with the mother reveals the following facts: history of insanity on one side, poor environment, lack of hygiene.

The nurse, for once, takes us into her confidence: she would like to prevent tragedies of that sort—but how?

Since a well baby is the product of well parents, mentally and physically sound, is it not the duty of our governing bodies as well as of the man in the street, to promote with all their might the cause of Public Hygiene that covers such a great field, i.e., proper housing, careful supervision of the milk supply and of other food as well, eradication of dumps, replaced by incinerators, encouragement given to the private public health organisations, preventoria, special classes for the mentally retarded children, vocational guidance when they leave school.

We often hear that a chain is as strong as its weakest link, therefore we may state that all the movements mentioned above, constitute a long chain which is as strong as its weakest link.

It is obvious that a Child Welfare movement in a city, where the death-rate ranks abnormally high, that it has not all the support it needs.

Where is the weakest link in your city?

VISIT TO STE. AGATHE DES MONTS

Two motor coaches were inadequate to carry members of the International Council of Nurses to Ste. Agathe des Monts, where they were guests of the Laurentian Sanatorium on Friday, July 12th.

Before making a tour of the buildings, the senior medical assistant gave a brief history of the institution and an outline of tuberculosis control efforts in the Province of Quebec.

The visitors were shown the entire plant which is beautifully situated with attractive garden and grounds in the Laurentian Mountains, about 65 miles north of Montreal.

Greatly interested in everything, many of the nurses were attracted towards the Post Graduate Course for Nurses, which is offered by the Sanatorium—a number voiced the intention of returning at an early date.

BOOK REVIEW

A Text-Book of Eye, Ear, Nose & Throat Nursing, by Abby-Helen Dennison, R.N., Graduate Massachusetts General Hospital Training School for Nurses, Boston, Mass., Instructor Massachusetts Eye, Ear Infirmary, Boston, Mass. Published by The Macmillan Company of Canada, Toronto. Price $3.25.

Sections of this book deal with the anatomy of the eye, ear, nose and throat separately, followed by chapters on drugs and solutions, abbreviations, instruction and procedures, treatment and surgical supplies.

Chapters are devoted to the diseases peculiar to the eye, ear, nose and throat, and special points in treatment and nursing care, also preparation for patient for the several operations, post-operative care, removal of foreign bodies, etc. Lists of instruments and equipment for operation with illustrations are given. There are special instructions for giving treatment to restive children. A very comprehensive description of equipment used, and technique followed, in Out-Patient Department is also given.

The last chapter deals with social service and follow-up work as an essential part of hospital work of today. The therapeutic measures and practical procedures described in this book are those which are used at the Massachusetts Eye and Ear Infirmary.

This book will be of assistance to instructors in outlining courses of instruction in this work; it will also prove valuable to the student or older graduates who wish to brush up in this particular line.

—Olive A. MacKay,
Miramichi Hospital,
Newcastle, N.B.

BOOKS RECEIVED

A Text-Book of Anatomy and Physiology, by Jesse Feiring Williams, Teachers College, Columbia University. Third edition, illustrated. Price $2.75.

Bandaging, by A. D. Whiting, M.D. Third edition. Price $1.75.

Reference Hand-Book for Nurses, by Amanda K. Beck, R.N. Sixth edition, revised. Price $1.50.

Home Care of the Sick, by Norma Selbert, R.N., B.S., Assistant Professor of Public Health, College of Medicine, Ohio State University. Price $1.00.

All these books are published by W. B. Saunders Company: Canadian agents, McAinsh & Company, Ltd., Toronto, Ont.

A Text-Book of Materia Medica for Nurses, by Edith P. Brodie, B.A., R.N., Director of the School of Nursing, Vanderbilt University, Nashville, Tenn. Third edition. Price $2.00.

Principles of Chemistry, by Joseph H. Roe, Ph.D., Central School of Nursing, Washington, D.C. Second edition. Price $2.50. Published by C. V. Mosby Company. Canadian agents: McAinsh & Co., Ltd., Toronto.

News Notes

BRITISH COLUMBIA

Miss Margaret Kerr, B.A.Sc. (Nursing), a graduate of the five year course of the University of British Columbia, 1927, has obtained her Master's Degree from Columbia University, New York. Miss Kerr served for a time as a member of the school nursing service, in Nanaimo, B.C. Receiving a Rockefeller Scholarship, she attended Columbia University, and later studied public health under the auspices of the Rockefeller Foundation.

MANITOBA

A joint meeting of the Manitoba Association of Registered Nurses and the Manitoba Hospital Association was held in Winnipeg on September 12th and 13th.

Business sessions were held separately. Members of the M.A.R.N. held a general discussion of the Survey of Training Schools (made in 1928), and amendments to the Nurses Registration Act.

Guest speakers at the joint meetings were: Miss Mary E. Gladwin, Superintendent of Nurses, St. Mary's School of Nursing, Rochester, Minn., whose subjects were: "Value of Training School Inspection and the Future of Nursing Education," and "Value of Standard Technique in Communicable Diseases"; Dr. F. W. Jackson, Communicable Disease Section, Department of Health and Public Welfare, who spoke on "Communicable Diseases and the General Hospital"; and Dr. Harvey Agnew, Secretary, Department of Hospital Service, Canadian Medical Association, who prepared a paper on "Observation on Hospital Trends in Canada," which was read by Dr. G. S. Young, Assistant Professor of Medicine, University of Toronto.

BRANDON: Dr. Mary McKenzie has recently joined the staff of the Hospital for Mental Diseases.

Miss E. McNally represented the Brandon Graduate Nurses Association at the I.C.N. Congress. Others attending were: Misses S. Birtles, C. McLeod, E. Birtles, D. Cameron, I. Schofield, H. Meadows, and J. Fenton.

Mrs. (Dr.) Geo. J. Miller (Annie Francis), of Fort Frances, was a visitor to Brandon recently.

GENERAL HOSPITAL, WINNIPEG: Appointments: Misses Ethel Wilson (1929), and Enid Brown (1929), to the staff, General Hospital, Ambrose, N.D.

Miss Helen Holloway (1924), to the staff of the hospital at Minnedosa, Man.

Miss Iris Bennett (1927), to the staff of the Social Service Department, Psychopathic Hospital, Winnipeg.

Miss Elizabeth Pearston (1924), to the position of lady superintendent at the hospital at Grand Prairie, Alta. Miss Pearston was a member of the teaching staff for the past five years.

Miss Jessie Munro (1923), to a position as X-ray technician in Saskatoon.

Miss Mary Cameron (1926), to the staff, Winnipeg General Hospital.

Miss Gretchen Goulding (1918), has resigned from the staff of the Social Service Department, Psychopathic Hospital, Winnipeg.

Mrs. Dr. Burns (Florence Cromie, 1921), of Derby, Conn., visited in Winnipeg during August.

Miss Ada Luross (1924), of California, visited in Winnipeg during July.

Miss Mabel Andrew (1923), of Hollywood, Cal., visited in Winnipeg on her return from the Congress in Montreal.

Our graduates were happy to see that among those registered at the Congress in Montreal was Miss M. Eleanor Birtles (1889), the oldest graduate of the hospital.

NEW BRUNSWICK

GENERAL PUBLIC HOSPITAL, SAINT JOHN: On August 27th, Miss Elsie Shaw was tendered a shower at the home of Mrs. J. H. Vaughan, president of the Alumnae. Many pieces of flat silver were presented to the guest of honour.

Misses Inez Whipple and Chrissie Shand, were entertained at a handkerchief shower by the graduates prior to leaving for Winnipeg and Toronto, respectively.

Miss Evelyn Bedford spent her vacation in Saint John.

NOVA SCOTIA

At the regular monthly meeting in August, of the Wolfville Branch, Victorian Order of Nurses, a presentation of $25.00 in gold was made to Miss Mary Harry, who has been on the staff since its inception, eighteen years ago. Miss Harry, who recently resigned, has joined the Frontier Nursing Service of Kentucky, U.S.A.

ONTARIO

APPOINTMENTS

Paid-up subscriptions to "The Canadian Nurse" for Ontario in September, 1929, were 1,253. Fifty more than in July, 1929.

Miss B. Parker (Hamilton General Hospital, 1914), to the staff of the Hospital, and is in charge of Ward 7.

Miss Jessie Jackson (Hamilton General Hospital, 1927), to the position of assistant night supervisor at the Hospital.

Miss Pauline Steves (Toronto General Hospital, 1928; Public Health Nursing, University of Toronto), to a position in the Social Service Department, Toronto General Hospital.

Miss Moseley (Toronto General Hospital, 1927; Public Health Nursing, University of Toronto), has been relieving on the Social Service staff, Toronto General Hospital.

Miss Janet Murray (Hamilton General Hospital, 1927), to the operating room of the Hospital.

Miss Helen Aitken (Hamilton General Hospital, 1925), and Miss Mary Lanford (1926), to the Mount Hamilton Hospital.

Miss S. Livett has succeeded Miss H. Ion on the staff of the Brantford General Hospital.

Miss T. Dawson to the staff of the Brantford General Hospital; Miss F. Keffer having resigned.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Miss Ida M. Gardiner who has been engaged in outpost duty for the Red Cross Hospital at Redditt, Ontario, has been awarded a scholarship and entered Western University, London, on September 23rd for a post-graduate course.

Misses Cora Taylor, Alberta Creasor, and Anna Coutts are all taking the Public Health Course at the University of Toronto this year.

The Mutual Benefit Association is having a drive for new members, and we would like to impress on all those who have not joined, the benefits to be derived therefrom.

Miss M. McFarlane (1926), former assistant night supervisor, has taken up private duty nursing.

Miss Ada Schiefele (1923), is at home on furlough from India.

Miss Myrtle Harrod (1926), has resigned her position in the operating room.

DISTRICT 5

WELLESLEY HOSPITAL, TORONTO: At the May meeting of the Alumnae, Miss Gertrude Ross, newly appointed superintendent was introduced to the large number of graduates present. It was with great pleasure that they welcomed her to the Training School.

Twenty-five nurses graduated on June 15. Ideal weather and the beautiful grounds of the Hospital made the setting for the colourful graduating exercises. Dr. J. E. Elliott, Toronto, gave a most appropriate address.

The new residence of the Hospital was the scene of a large gathering of graduate and undergraduate nurses, when Miss Bastedo (1915), on behalf of the Alumnae presented the Training School with a beautiful portrait of the late Miss Elizabeth Flaws. The gift was accepted by one member of each class for the school.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: Miss E. Morris (1915), who has been doing summer relief work at the Hospital, has accepted a position in the Infirmary at St. Johns, Nfld.

Misses F. B. Laite (1924), who is doing V.O.N. work in Moncton, N.B.; M. Bailleul (1925), of Winsted, Conn., and G. Fitzgerald (1928), of St. Johns, Nfld., were among those who attended the I.C.N. Congress in Montreal.

Miss A. Thompson (1926), has resigned her position as night supervisor and is at present visiting relatives in Western Canada. She has been replaced by Miss B. Goobie (1929).

Miss I. Stewart (1927), has resigned her position on the staff of the Woman's Hospital, Montreal, and has gone to her home in Glasgow, Scotland, where she intends doing school nursing.

Miss Feader (1929), who did summer relief work at the Hospital has gone home to Chester, N.S.

Miss R. Miller (1928), is now with the V.O.N. in Montreal.

Miss A. MacFarland (1928), is stationed in Huntsville, Ont., with the V.O.N.

Miss V. Ford (1928), after spending some time in Nova Scotia has resumed special duty in Montreal.

Sympathy of the members of the Alumnae is extended to Mrs. W. Francis in the loss of her father.

GENERAL HOSPITAL, MONTREAL: Miss Welling has been appointed second assistant in the Training School office.

Miss Wills has joined the teaching staff.

Miss Reinauer has become charge sister in Ward "L."

Miss Donavan has resigned as night supervisor from the Woman's General Hospital and accepted a position as assistant supervisor at the Miramichi Hospital, Newcastle, N.B.

Misses H. Carmon, K. Wilson, E. MacNutt, have returned after spending the summer abroad.

The sympathy of the Alumnae is extended to Miss Agnes Bulloch in the loss of her brother.

WOMAN'S GENERAL HOSPITAL, WESTMOUNT Miss Sholit (1915), of Los Angeles, Cal., attended the I.C.N. Congress.

Misses Margaret Paterson and Abramovitch (1929), were relieving at the Hospital during the holiday season, and are now doing private nursing in the city.

Miss Margaret Crayman (1929), is in charge of the Nursery at the Hospital.

Miss M. Blower (1928), has returned from a visit to England.

Miss Ruth Jackson (1928), is in Truro, N.S.

Mrs. Crewe (1919), spent a month in Prince Edward Island.

Miss N. J. Brown (1925), visited in Kingston, Ont., during the month of August.

SASKATCHEWAN

The first scholarship offered by the Saskatchewan Registered Nurses Association was awarded this year to Miss Edith Amas, of Qu'Appelle, Sask. Miss Amas is a graduate of Saskatoon City Hospital, (1923) and held, on entering training, the Lieutenant-Governor's Medal for high school work and the Red Cross Scholarship.

The scholarship of five hundred dollars is to enable the student to spend one year in university, studying Teaching and Adminis-

tration in Schools of Nursing, after which she must return to Saskatchewan to spend at least two years in a Saskatchewan Training School for Nurses. Miss Amas enters McGill University this fall.

Mrs. Margaret F. Myles has resigned her position as Superintendent of the Queen Victoria Hospital, Yorkton, Sask., and enters McGill University this fall, to take a course in Administration in Schools of Nursing.

CITY HOSPITAL, SASKATOON: APPOINTMENTS: Miss Kate MacLean (1922), to the staff of the Sanatorium, Saskatoon, Sask.

Mrs. Ina Hill (1922), has accepted the position of Matron, Boy's College, Battleford.

Miss Jean Watson (Mountain Side Hospital, New Jersey), to position as Superintendent of Nurses, Saskatoon City Hospital.

Miss Ellen Hettle (1928), who underwent a serious operation recently, is reported to be making favourable progress. She is with her mother, 1015 South Benito Ave., Alhambra.

REGINA: The regular meeting of the Alumnae of the Regina General Hospital was held at the home of the president on September 12th. The secretary-treasurer reported the Alumnae to be in good financial position. Plans were made for a tea and sale of aprons, knitted articles and home cooking.

Miss Wanley has accepted a position at the Shaunavon Hospital.

VICTORIAN ORDER OF NURSES

APPOINTMENTS

Miss Marion Wismer (University of British Columbia), assistant Vancouver staff.

Miss Mary McCuaig, nurse-in-charge, Edmonton District; Miss Marjorie Baird having resigned.

Miss Eileen Wright (University of British Columbia), to district of Preeceville-Clayton, Sask.

Miss Madeline Taylor, charge of the newly opened district of Regina.

Miss Mabel Fillmore (Saint John's staff), the district of Dartmouth, N.S.

Miss Faye Saunders, of Halifax, the district of Lunenburg.

RESIGNATIONS:

Miss Clara Shields and Miss C. Van Allen, resigned from the Winnipeg staff (to be married).

Miss Mary Harry (Wolfville Branch), resigned, to take a position with the Frontier Nursing Service, Kentucky.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

ANDERSON—On August 13, 1929, to Dr. and Mrs. Lloyd Anderson (Emily Sproule, Saskatoon City Hospital, 1922), a son.

BENNETT—Recently, at Toronto, Ont., to Mr. and Mrs. G. C. Bennett (Olive Bennett, Wellesley Hospital, Toronto, 1922), a son.

DONNER—On July 15, 1929, at Saint John, N.B., to Mr. and Mrs. George Donner (Clara Nixon, General Public Hospital, 1928), a son.

FLETT—On August 10, 1929, at Toronto, to Mr. and Mrs. Flett (Dorothea Burton, Wellesley Hospital, Toronto, 1926), a daughter.

FULLER—On August 6, 1929, at Napanee, Ont., to Mr. and Mrs. G. B. Fuller (Marguerite Pringle, Wellesley Hospital, Toronto, 1922), a son.

GIFFIN—On August 22, 1929, to Mr. and Mrs. William Giffin (Mildred Grady, Saskatoon City Hospital, 1925), a son (Douglas Hamford).

GUNN—On August 21, 1929, at Fort Frances, Ont., to Dr. and Mrs. Lynn Gunn (Melrose King, Winnipeg General Hospital, 1925), a daughter.

HANSEN—On May 18, 1929, at Winnipeg, to Mr. and Mrs. S. L. Hansen (Edith Archibald, Winnipeg General Hospital, 1926), a daughter.

HARRIS — Recently, at Mt. Hamilton, Ont., to Mr. and Mrs. Harris (Gladys Tighe, Hamilton General Hospital, 1921), a son.

HOGEBOON—On July 14, 1929, at Winnipeg, to Mr. and Mrs. L. K. Hogeboon (Miss Watson, Winnipeg General Hospital, 1925), a son.

LAWRENCE—On August 1, 1929, to Mr. and Mrs. Lawrence (Grace Occomon, General and Marine Hospital, Collingwood, 1918), a son.

MULLENS—On September 2, 1929, at Hamilton, Ont., to Mr. and Mrs. S. Mullens (Louise Wood, Hamilton General Hospital, 1927), a son.

MUSGROVE—On June 25, 1929, at Winnipeg, to Dr. and Mrs. W. M. Musgrove (Thelma Mason, Winnipeg General Hospital, 1924), a daughter.

McINNES—On July 10, 1929, at Winnipeg, to Mr. and Mrs. Robert McInnes (Muriel Ross, Winnipeg General Hospital, 1918), a son.

McKAY—Recently, at Hamilton, Ont., to Dr. and Mrs. A. J. McKay (Roberta Pratt, Hamilton General Hospital, 1925), a son.

McKAY—In July, at Toronto, to Dr. and Mrs. Angus McKay (Ted Hanna, Toronto General Hospital, 1916), a daughter.

PAGE—On August 21, 1929, at Hamilton, Ont., to Dr. and Mrs. L. Page (Ethel Davidson, Hamilton General Hospital, 1922), a daughter.

RENNICK—Recently, at Kitchener, Ont., to Mr. and Mrs. H. Rennick (Jessie Spence, Hamilton General Hospital, 1925), a son (Bruce William).

ROBERTSON—On May 9, 1929, at Ipah, Perak, F.M.S., to Mr. and Mrs. D. S. Robertson (Gladys Risk, North Bay Hospital, 1924), a daughter (Margaret).

ROY—On June 24, 1929, to Mr. and Mrs. Stuart Roy (Hilda Merritt, Hamilton General Hospital, 1925), a daughter (Frances Ann Elizabeth).

SINCLAIR—Recently, at Winnipeg, to Mr. and Mrs. D. Sinclair (Gertrude Bloomfield, Winnipeg General Hospital, 1926), a daughter.

MARRIAGES

ALLEN—HANCOCK—In June, 1929, at Port Hope, Ont., Muriel Hancock (Wellesley Hospital, 1927), to Clarence Allen, Newcastle, Ont.

AUSTMAN—HERMANSON — On August 10, 1929, Wildora Hermanson (Winnipeg General Hospital, 1928), to John J. Austman, Winnipeg, Man.

BAIRD—MUNROE—On July 17, 1929, at New Glasgow, N.S., Jean MacElvie Munroe (Victoria General Hospital) to Harold E. Baird, M.D., C.M., of Chipman, N.B.

BRAIS—BREWSTER — On August 19, 1929, at Saint John, N.B., Dorothy Louis Brewster (Montreal General Hospital, 1927), to Louis Alexis Brais.

CHRISTIE—CLARK—On August 17, 1929, at Hamilton, Ont., Bessie I. Clark (Hamilton General Hospital, 1928), to R. J. Christie, Mount Hamilton, Ont.

CLARK—BRECKON — On September 4, 1929, at Winnipeg, Lottie Breckon (Winnipeg General Hospital, 1927), to Bert Clark, Fort Frances, Ont.

DARGAUELL—McVANELL — On April 13, 1929, at Wiarton, Ont., Mary McVannell (Woodstock General Hospital, 1922), to Clark Dargauell, Wiarton, Ont.

DICKIE—SMELTZER—On July 1, 1929, at Mahone Bay, N.S., Marion Gertrude Smeltzer to David M. Dickie. At home, Canning, N.S.

DOLE—DOANE—On July 10, 1929, at Barrington, N.S., J. Gunheld Doane to Howard Louis Dole, Waynesburg, Pa.

DONALDSON—GEE—On June 1, 1929, at Winnipeg, Gladys Gee (Winnipeg General Hospital, 1928), to Gordon William Donaldson, of Edmonton, Alberta.

EMPEY—ELLIS—On August 13, 1929, at Iroquois, Ont., Luella Mabel Ellis (Wellesley Hospital, 1929), to Stewart F. Empey.

FAIRBAIRN—CRAIG—On June 29, 1929, at Winnipeg, Kathleen Craig (Winnipeg General Hospital, 1926), to Dr. Logan Fairbairn.

FARRELL—BARDAL — On August 21, 1929, at Saskatoon, Sask., Svava Bardal (Winnipeg General Hospital, 1927), to Lorne Farrell.

FENTON—SMITHSON — In June, Marguerite Smithson (Toronto General Hospital, 1921), to Robert Fenton.

FRASER—GORDON—On August 14, 1929, at Grenfell, Sask., Ivy Gordon (Winnipeg General Hospital, 1927), to G. R. Fraser, Neepawa, Man.

FRY—FIDLIN—On August 31, 1929, at Norwich, Ont., Inez Fidlin (Hamilton General Hospital, 1927), to H. Fry.

FULLERTON—STACK — On August 31, 1929, at Knowlton, P.Q., Dorothy Stack (Montreal General Hospital, 1927), to Dr. Charles W. Fullerton.

GALBRAITH—McCANN—On August 24, 1929, at Regina, Sask., Violet McCann (Saskatoon City Hospital, 1927), to Charlie Galbraith.

GRIEVE—MACPHERSON — On August 20, 1929, at Vancouver, B.C., Frances Emma MacPherson (Victoria Hospital, London, Ont., 1918), to Charles Grieve, Baroona Bay Road, Glen Osmond, South Australia.

HEROLD—MACDONALD — On July 10, 1929, at Burlington, Margaret MacDonald (Hamilton General Hospital, 1927), to Alfred Herold.

HORTON—LANGLEY—On June 29, 1929, at New Hampshire, Miss Langley of Port Hawkesbury, C.B., to Ralph Horton.

HULL—HEISEY—On June 22, 1929, at New York, Luella Heisey (Wellesley Hospital, 1917), to J. Hull, New York.

JONES—GARRIOCH—On June 19, 1929, at Sacramento, California, Jean Garrioch (Winnipeg General Hospital, 1920), to Gordon Jones.

KING—PARSONS—On August 24, 1929, at Cayuga, Ont., Ella Parsons (Hamilton General Hospital, 1927), to Francis King, of Cayuga.

LEDINGHAM—DUNCAN — On June 26, 1929, at Owen Sound, Ont., Margaret Duncan (General and Marine Hospital, 1927), to George M. Ledingham, Souris, Man.

MARTIN—WHITE—On May 16, 1929, at Woodstock, Ont., Luella Annie White (Woodstock General Hospital, 1928), to E. L. Martin, Woodstock, Ont.

MERRETT—NEELAN—On June 1, 1929, at Swan Lake, Man., Violet Neelan (Winnipeg General Hospital, 1928), to Dr. Paul Merrett, Winnipeg.

McARTHUR—FERGUSON — On August 19, 1929, Bessie Irene Ferguson (Saskatoon City Hospital, 1921), to Melvin Clarke McArthur, Toronto, Ont.

McCAUSLAND—SHERMAN—On August 15, 1929, at Toronto, Ont., Jessie Sherman (Woodstock General Hospital, 1923), to John McCausland, North Bay, Ont.

McCLUSKEY—McDONAUGH — On June 22, 1929, May McDonaugh (Toronto General Hospital, 1926), to Dr. McCluskey.

McKENNA—GREENAN—On July 3, 1929, at Kinkora, P.E.I., Annie Madeline Greenan (City Hospital, Charlottetown, P.E.I., 1925), to J. M. McKenna, Maple Creek, Sask.

McMILLAN—BARBOUR—On August 14, 1929, at Saltcoats, Sask., Edith Barbour (Winnipeg General Hospital, 1927), to Joe McMillan, Brandon, Man.

OLSON—VAN ALLEN—In July, 1929, at Winnipeg, Catherine Van Allen (Winnipeg General Hospital, 1920), to William Olson, Winnipeg, Man.

PHIN—KOPEMAN—In August, 1929, at Hespeler, Ont., Florence Kopeman (Wellesley Hospital, 1926), to Robert Phin.

POTTER—BOUDREY—Recently, at Hamilton, Ont., Doreen Boudrey (Hamilton General Hospital, 1928), to Reg. Potter.

PUDDICOMB—MORRIS — On July 10, 1929, at Windsor, N.S., Clara Hamilton Morris to John Francis Heins Puddicomb, M.D., C.M., Ottawa, Ont.

SAVAGE—NORQUAY—On May 21, 1929, at St. Andrews, Man., Mary Norquay (Winnipeg General Hospital, 1928), to Alfred Savage, B.Sc., of Winnipeg.

SOBY—HANSON—On August 8, 1929, at Calgary, Alta., Anne Hanson (Children's Memorial Hospital, 1926), to Harold Soby, M.D. At home, Highwater, Alta.

SOUTER—HARROD—On September 21, 1929, at Palermo, Ont., Myrtle I. Harrod (Hamilton General Hospital, 1926), to W. E. Souter, Hamilton, Ont.

STEWART—SHIELDS—On June 8, 1929, at Winnipeg, Clara Shields (Winnipeg General Hospital, 1921), to Nelson Stewart, Jasper, Alberta.

SWICKER—SHAW — On September 3, 1929, at Saint John, N.B., Elsie Josephine Shaw (General Public Hospital, 1919), to G. Russell Swicker, Worcester, Mass.

TARLETON—LENNON—On August 31, 1929, at Montreal, Irene Lennon (Children's Memorial Hospital, 1926), to Gordon Tarleton. At home, Outremont, Montreal.

UREN—McGUFFIN—On June 20, 1929, Mildred McGuffin (Toronto General Hospital, 1926), to Dr. Lester Uren.

WARD—McLEOD—On September 3, 1929, at Winnipeg, Man., Frances McLeod (Winnipeg General Hospital, 1924), to Stanley Ward, Winnipeg.

WEBSTER—LYKE—On August 24, 1929, Marie Lyke (Saskatoon City Hospital, 1927), to David Webster, Saskatoon, Sask.

DEATHS

HOLLOWAY—On July 18, 1929, Edna Kathleen Holloway (Victoria General Hospital, Halifax, 1920).

JENNINGS—On July 28, 1929, at St. Catharines, Ont., Grace Jennings (Wellesley Hospital, Toronto, 1927).

PENWARDEN—On July 28, 1929, at Boston, Mass., Margaret Penwarden (MacLean Hospital, Waverley, Mass.), daughter of Rev. B. H. and Mrs. Penwarden, Windsor, N.S.

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REGISTRATION OF NURSES
PROVINCE OF ONTARIO

Examination Announcement

An examination for the Registration of Nurses in the Province of Ontario will be held in November.

Application forms, information regarding subjects of examination, and general information relating thereto, may be had upon written application to Miss A. M. Munn, Reg. N., Parliament Buildings, Toronto No candidate will be considered for examination unless the completed application form accompanied by the examination fee of $5.00, is received by the Inspector, before November 10th, 1929.

Signed—

A. M. MUNN, Reg.N.,
Inspector of Training Schools

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Regular Meeting—First Tuesday in Month.

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Meetings—Second Wednesday each month, 8 p.m., St. Boniface Nurses Residence.

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Hon. President, Sister M. Pascal; Hon. Vice-President, Sister St. Elizabeth; President, Miss A. Costello; First Vice-President, Mrs. J. Nolan; Second Vice-President, Miss L. Morrison; Corresponding Secretary, Miss N. Barr; Recording Secretary, Miss H. Mullins; Treasurer, Miss E. Beger, 27 Yale St.; Representative, Board of Central Registry, Miss A. Costello.

A.A., VICTORIA HOSPITAL, LONDON, ONT.

Hon. President, Miss Grace M. Fairley, Victoria Hospital; President, Miss Della Foster, 503 St. James Street; First Vice-President, Miss Mary Yule, 151 Bathurst St.; Second Vice-President, Miss Christena Gillies, Victoria Hospital; Treasurer, Miss Edith Smallman, 814 Dundas Street; Secretary, Miss Isobel Hunt, 898 Princess Avenue; Corresponding Secretary, Miss Mabel Hardie, 281 Queens Ave.; Representative, The Canadian Nurse, Miss Luella M. Shaw, Victoria Hospital; Board of Directors, Mrs. C. J. Rose, Misses F. MacPherson, H. Hueston, E. Swetnam, H. Cryderman, A. McKay; Representatives to Registry Board, Misses M. McVicar, S. Giffen, F. Macpherson and A. Johnston.

A.A., NIAGARA FALLS GENERAL HOSPITAL

Hon. President, Miss M. S. Park; President, Miss Marion Curry; First Vice-President, Mrs. M. E. Sharpe; Second Vice-President, Mrs. D. O'Donnell; Treasurer, Mrs. N. Gillies; Secretary, Miss H. J. Pirie; Convener, Sick Committee, Mrs. V. Wesley; Asst. Convener, Sick Committee, Mrs. J. Taylor; Convener, Private Duty Committee, Miss A. I. Pirie.

A.A., ORILLIA SOLDIERS' MEMORIAL HOSPITAL

Honorary President, Miss E. Johnston; President, Miss M. Harvie; First Vice-President, Miss M. Payne; Second Vice-President, Miss A. Dudenhoffer; Secretary-Treasurer, Miss Gladys M. Went; Programme Committee, Misses C. Newton, M. Stephen, F. Graham; Visiting Committee, Misses G. Adams, E. Mitchell, F. Pearce.

Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

Hon. President, Miss E. MacWilliams; President, Mrs. H. W. Trick, 168 Simcoe St. N.; Vice-President, Miss Jane Cole; Secretary and Corresponding Secretary, Miss Elma M. Hogarth, 301 Celina Street; Treasurer, Mrs. H. Harland, 50 McMillan Drive.

A.A., ST. LUKE'S HOSPITAL, OTTAWA

President, Miss Isabel Mothersill; Vice-President, Miss Mary Nelson; Secretary, Miss Isabel Allan, 408 Slater St.; Treasurer, Mrs. Florence Ellis; Representatives to Central Registry, Miss Grace Woods and Miss Norma Lewis; Representative to the Local Council of Women, Miss Mona Drummond.

A.A., LADY STANLEY INSTITUTE, OTTAWA (Incorporated 1918)

Hon. President, Miss M. A. Catton, 2 Regent St.; Hon. Vice-President, Miss Florence Potts; President, Miss Mabel M. Stewart, Royal Ottawa Sanatorium; Vice-President, Miss M. McNiece, Perley Home, Aylmer Ave.; Secretary, Mrs. G. O. Skuce, Britannia Bay, Ont.; Treasurer, Miss C. Slinn, 204 Stanley Ave.; Board of Directors, Miss E. MacGibbon, 114 Carling Ave.; Miss C. Flack, 152 First Ave.; Miss E. McColl, Vimy Apts., Charlotte St.; Miss L. Belford, Perley Home, Aylmer Ave.; "Canadian Nurse" Representative Miss A. Ebbs, 80 Hamilton Ave.; Representatives to Central Registry Nurses, Miss A. Ebbs, 80 Hamilton Ave.; Miss Mary C. Slinn, 204 Stanley Ave.; Press Representative, Mrs. J. Waddell, 220 Waverley St.

A.A., OTTAWA GENERAL HOSPITAL

Hon. President, Rev. Sister Flavia; President, Mrs. John Murphy; First Vice-President, Miss Florence Nevins; Second Vice-President, Mrs. A. Latimer; Secretary-Treasurer, Miss Viola Foran, 557 Laurier Ave., West; Membership Secretary, Miss Pauline Bissonnette; The Canadian Nurse, Miss Juliet Robert; Representatives to The Local Council of Women, Mrs. C. L. Devitt, Mrs. A. Latimer, Mrs. E. Vian, Miss F. Nevins; Representatives to Central Registry, Miss A. Stackpole, Miss L. Egan, and a member of each class.

A. A., GENERAL AND MARINE HOSPITAL OWEN SOUND.

Hon. President Miss Edith Jefferies; President, Miss E. Webster 1022 4th Ave. W.; Vice-President, Miss Cora Thompson; Secretary-Treasurer, Miss Cora Stewart, General and Marine Hospital; Asst. Secretary-Treasurer, Mrs. D. J. McMillan; Flower Committee, Mrs. Wm. Forgrave, Mrs D. J. McMillan, Miss C. McLean; Programme Committee, Misses Olga Stewart, Grace Rusk, Mary Graham; Press Representative, Miss Mary Sim.

A.A., NICHOLL'S HOSPITAL, PETERBORO.

President, Miss F. Dixon; First Vice-President, Miss E. B. Walsh; Second Vice-President, Miss H. Anderson; Treasurer, Miss M. R. Reid; Secretary, Miss B. Smith; Corresponding Secretary, Miss J. Deyell, Y.W.C.A.; Convener, Social Committee, Miss M. Watson; Convener, Flower Committee, Miss A. Dobbin.

A.A., SARNIA GENERAL HOSPITAL

Hon. President, Miss K. Scott; President, Miss D. Shaw; Vice-President, Miss L. Barwise; 2nd Vice-President, Miss L. Seigrist; Treasurer, Miss M. Lee; Secretary, Miss B. M. Farlane.

A.A., SAULT STE. MARIE GENERAL HOSPITAL

Hon. President, Rev. Sister Mary Dorothea; President, Miss Lillian Goatbe; First Vice-President, Mrs. J. O'Driscoll; Second Vice-President, Miss Stella Kehoe; Secretary, Miss Dora Baxter; Treasurer, Miss B. Spence.

A.A., STRATFORD GENERAL HOSPITAL

Hon. President, Miss A. M. Munn; President, Miss S. Meyschein; Vice-President, Miss C. Staples; Secretary-Treasurer, Miss L. M. Wilks; Flower Committee, Mrs. L. Dunsmore, Miss A. Turnbull; Correspondent, "The Canadian Nurse," Miss C. J. Zoeger.

A. A., MACK TRAINING SCHOOL, ST. CATHARINES.

Hon. President, Miss A. Wright, Superintendent General Hospital; President, Mrs. Charles Hesburn, 54 George St.; First Vice-President, Mrs. Parnell, 161 Church St.; Second Vice-President, Miss Tuck, 106 Church St.; Secretary-Treasurer, Miss Ethel Whittington, General Hospital; Assistant Secretary-Treasurer, Miss Mary Phippe, 82 Hainer St.; Programme Committee, Mrs. Ockenden, Misses F. McArter, A. Johnston and F. Case; Social Committee, Misses B. Kennedy, A. Moyer, R. Beckett, A. Gayman and Mrs. F. Newman; "The Canadian Nurse" Representative, Mrs. Parnell; "The Canadian Nurse," Subscriptions, Miss F. McArter; Press Correspondent, Miss S. E. Hanna.

A.A., MEMORIAL HOSPITAL, ST. THOMAS

Hon. President, Miss Lucille Armstrong, Memorial Hospital; Hon. Vice-President, Miss Mary Buchanan, Memorial Hospital; President, Miss Jessie Grant, Memorial Hospital; First Vice-President, Miss Jean Killins; Second Vice-President, Miss Hazel Hastings; Secretary, Miss Annie Campbell, Memorial Hospital; Corresponding Secretary, Miss Gladys Hardy, 19 Weldon Avenue; Treasurer, Miss Mary Malcolm, 142 Centre Street; The Canadian Nurse, Mrs. Thomas Keith, 47 William St.; Executive, Mrs. J. A. Campbell, Misses Isabel Matheson, Roma Chambers, Elinor Raman, Claribel McCorquodale.

A.A., TORONTO GENERAL HOSPITAL

Hon. President, Miss M. A. Snively; Hon. Vice-President, Miss Jean Gunn; President, Miss Jean Browne; 1st Vice-President, Miss Hunter; 2nd Vice-President, Miss M. Crossley; Treasurers, The Misses Fidler, Nurses' Residence, Toronto General Hospital; Corresponding Secretary, Miss L. Bailey; Recording Secretary, Miss M. Stewart; Councillors, Misses K. Russell, G. Gordon, C. Vale, M. Dulmage, McFarland.

A.A., GRACE HOSPITAL, TORONTO

Hon. President, Mrs. C. J. Currie; President, Mrs. John Gray; First Vice-President, Miss Alberta Bell; Second Vice-President, Miss L. J. Dyer; Recording Secretary, Miss Dewar; Corresponding Secretary, Miss Lila Edmunds, 282 Grace St.; Treasurer, Miss Elliott, 26 Tranby Ave.

A.A., GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO, ONT.

Hon. President, Miss Esther Cook, 130 Dunn Ave.; President, Mrs. Caroline Ash, 130 Dunn Avenue; Vice-President, Miss Jean Macpherson, 130 Dunn Avenue; Secretary, Miss Mary Crawford, 130 Dunn Avenue; Treasurer, Miss Amy Poff, 130 Dunn Avenue; Press Secretary, Miss Ione Clift, 130 Dunn Avenue; Convener, Social Committee, Miss Effie Carrie, 61 Roncesvalles Avenue.

A.A., TORONTO ORTHOPEDIC HOSPITAL

Hon. President, Miss E. McLean; President, Miss M. Devins, 42 Dorval Rd.; Vice-President, Mrs. W. J. Smithers, 74 St. George St.; Secretary-Treasurer, Miss O. Fee, 100 Bloor St. W.; Representatives to Central Registry: Mrs. Proctor, 226 Glen Rd.; Miss E. Kerr, 1594 King St. W.; Representative to R.N.A.O., Miss A. Bodely, 43 Metcalf St.

A.A., RIVERDALE HOSPITAL, TORONTO

President, Miss E. Lyall, 290 St. George St., Toronto; First Vice-President, Miss G. Gastrell, Isolation Hospital; Second Vice-President, Mrs. Radford, 458 Strathmore Blvd.; Secretary, Miss Cora L. Russell, Isolation Hospital; Corresponding Secretary, Mrs. E. Quirk, Isolation Hospital; Treasurer, Miss L. McLaughlin, Isolation Hospital; Conveners of Standing Committees: Sick and Visiting, Miss S. Stretton, 7 Edgewood Ave.; Programme, Miss K. Mathieson, Isolation Hospital; Representatives to Central Registry, Misses G. Anderson, J. Henderson.

A. A., HOSPITAL FOR SICK CHILDREN, TORONTO

Hon. President, Mrs. Goodson; Hon. Vice-Presidents, Miss F. J. Potts and Miss Kathleen Panton; President, Miss Hazel Hughes; First Vice-President, Mrs. A. L. Langford; Second Vice-President, Miss Gene Clark; Secretary, Miss Wilma Low, 274 Danforth Ave.; Corresponding Secretary, Mrs. D. M. Smith, 250 Heath St. W.; Treasurer, Mrs. A. P. Reid, 58 Hubbard Blvd.; Councillors, Miss Carson, Mrs. Strachan, Miss K. Halliwell, Miss Florence Booth, Mrs. T. A. James, Miss St. John.

A.A., ST. JOHN'S HOSPITAL, TORONTO

Hon. President, Sister Beatrice, St. John's Hospital; President, Miss Haslett, 48 Howland Ave.; First Vice-President, Miss Ramsden, 9 Carey Rd.; Second Vice-President, Miss Bowen, 9 Linden St.; Corresponding Secretary, Miss Magnan, 3 Ravina Cres.; Recording Secretary, Miss Coleman, 119 Wellesley Cres.; Treasurer, Miss Cook, 1192 Gerrard St. E.

A.A., ST. MICHAEL'S HOSPITAL, TORONTO

President, Miss Essie Taylor, 20 Lauder Ave., Toronto; First Vice-President, Miss Ella Graydon; Second Vice-President, Miss Ella O'Boyle; Third Vice-President, Miss Helen O'Sullivan; Recording Secretary, Miss Roselle Grogan; Corresponding Secretary, Miss Marie E. McEnaney, 62 Asiel St., Toronto; Treasurer, Miss Helen Hyland, 137 Belsize Drive, Toronto; Directors, Misses E. M. Chalue, M. I. Foy, Marcella Berger; Conveners of Standing Committees, Misses Ivy de Leon, Julia O'Connor, Hilda Kerr.

A.A., VICTORIA MEMORIAL HOSPITAL, TORONTO

Hon. President, Mrs. Forbes Godfrey; President, Miss Annie Pringle; Vice-President, Miss Dorothy Greer; Secretary, Miss Florence Lowe, 152 Kenilworth Ave., Toronto; Treasurer, Miss Ida Hawley, 41 Gloucester St., Toronto.

Regular Meeting—First Monday of each month.

A.A., WELLESLEY HOSPITAL, TORONTO

President, Miss Edith Carson, 496 Sherbourne St.; Vice-President, Miss Alice Brown, 40 Wroxeter St.; Treasurer, Miss Elda Rowan, 342 Spadina Rd.; Recording Secretary, Mrs. Florence Barry, 42 Maitland St.; Corresponding Secretary, Miss Jessie Campbell, 121 Carlton St.; Executive, Misses Tucker, Lavelle, Fraser and Meikle; Correspondent to "The Canadian Nurse," Miss Bernice Reid, 88 Carlton St.

A.A., TORONTO WESTERN HOSPITAL

Hon. President, Miss B. L. Ellis; President, Miss R. Beamish; Vice-President, Miss L. Smith; Recording Secretary, Miss F. Matthews; Secretary-Treasurer, Miss G. Jones; Representative to The Canadian Nurse, Miss E. Smith; Representative to Local Council, Mrs. MacConnell; Honorary Councillors, Mrs. Yorke and Mrs. MacConnell; Councillors, Mrs. Henders, Miss McLean, Miss Cooney, Miss L. Steacy, Mrs. Bateman, Miss Stevenson, Miss Milligan, Miss Grose; Social Committee, Mrs. A. Wilson; Flower Committee, Miss Lamont.

Meetings will be held the second Thursday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A. A., WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Mrs. Bowman; Hon. Vice-President, Miss Harriett T. Meiklejohn; President, Miss Hawkes; First Vice-President, Mrs. Akins; Second Vice-President, Miss Arksey; Treasurer, Mrs. Hood; Corresponding Secretary, Miss McClintock (first), Miss Groenswold (second); Recording Secretary, Miss Munns; Social Committee, Miss May; Representative to "The Canadian Nurse," Miss M. F. Snell, 21 Kelvin Manor Apts., 2161 Yonge St.

A.A. CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

Hon. President, Miss E. MacP. Dickson, Toronto Hospital, Weston; President, Miss Louise Smith, Toronto Hospital, Weston; Vice-President, Miss Ella Robertson, 137 Markham St., Toronto; Secretary, Miss Ruth MacKay, Toronto Hospital, Weston; Treasurer, Miss Clara Foy, 153 Concord Ave., Toronto.

A. A., GENERAL HOSPITAL, WOODSTOCK,

Hon. President, Miss Frances Sharpe; President; Mrs. J. McDiarmid; First Vice-President, Mrs. Melsome; Second Vice-President, Miss G. Boothby; Secretary, Miss A. Schofield; Asst. Secretary, Miss H. Brown; Treasurer, Miss E. Eby; Corresponding Secretary, Miss L. Jackson; Representative to "The Canadian Nurse," Miss A. Cook; Social Committee, Mrs. Melsome, Misses Kerr and Jackson; Programme Committee, Misses Hobbs, McKay, and Costello; Flower Committee, Misses Jefferson and Cook.

GRADUATE NURSES ASSOCIATION OF THE EASTERN TOWNSHIPS

Hon. President, Miss H. S. Buck, Superintendent Sherbrooke Hospital; President, Miss Doris Stevens; First Vice-President, Miss Ella Morrisette; Second Vice-President, Miss Rhena Work; Treasurer, Mrs. Oscar Stenson; Recording Secretary, Miss Helen Hetherington; Corresponding Secretary, Miss Margaret Robins; Representative to "The Canadian Nurse," Miss Carolyn Hornby. Box 324, Sherbrooke, P.Q.

A.A., LACHINE GENERAL HOSPITAL

Hon. President, Miss L. M. Brown; President, Miss B. A. Jobber; Vice-President, Miss M. McNutt; Secretary-Treasurer, Miss B. F. Lapierre, 9563 LaSalle Blvd., LaSalle, P.Q.; Executive Committee, Miss A. Talbot, Miss M. Lamb.

Meetings, first Monday each month.

MONTREAL GRADUATE NURSES' ASSOCIATION

Hon. President, Miss L. Phillips, 3626 St. Urbain St.; President, Miss C. V. Barrett; Royal Victoria Hospital; First Vice-President, Miss A. Jamieson, 1230 Bishop St.; Second Vice-President, Miss A. DesBrisay, 1230 Bishop St.; Secretary Treasurer, Miss J. A. Fletcher, 1230 Bishop St.; Day Registrar, Miss L. White, 1230 Bishop St.; Night Registrar, Miss E. Clarke, 1230 Bishop St.; Relief Registrar, Miss J. A. Fletcher, 1230 Bishop St.; Convener, Griffintown Club, Miss G. Colley, 261 Melville Ave., Westmount, P.Q.

Regular Meeting—First Tuesday, January, April, October, December.

A.A., CHILDREN'S MEMORIAL HOSPITAL, MONTREAL

Hon. President, Miss A. S. Kinder; President, Miss M. Watson; Vice-President, Miss I. Stewart, Secretary, Mrs. F. C. Martin, 228 Royal Avenue; Treasurer, Miss M. Flanders; Sick Nurses Committee, Miss M. Clarke, Miss A. MacFarland; Representative to "The Canadian Nurse," Miss D. Parry; Members of Executive Committee, Misses E. Hogue, E. Hillyard.

A.A., MONTREAL GENERAL HOSPITAL

President, Miss F. E. Strumm; First Vice-President, Miss E. M. Cowen; Second Vice-President, Miss M. K. Holt; Recording Secretary, Miss M. P. Boa; Corresponding Secretary, Miss H. G. Hewton; Treasurer, Alumnae Association and Mutual Benefit Fund, Miss I. Davies; Hon. Treasurer, Miss Dunlop; Executive Committee, Misses Loggie, M. McDermott, Batson, McCarogher, Mathewson; Representative Private Duty Section, Miss R. Loggie; Representative to "The Canadian Nurse" (Convener), Miss White; Representative, Local Council of Women, Misses Colley, Bullock, Proxy, H. Carmen; Sick Visiting Committee (Convener), Mrs. Stuart Ramsay; Refreshment Committee, Misses Ward and L. Shepherd.

A.A., HOMOEOPATHIC HOSPITAL, MONTREAL

Hon. President, Mrs. H. Pollock; President, Mrs. M. I. Warren; First Vice-President, Miss T. Y. Sanders. Second Vice-President, Miss D. Campbell; Secretary, Miss Muriel Bright; Assistant Secretary, Miss M. McKenzie; Treasurer, Miss D. W. Miller; "The Canadian Nurse" Representative, Miss A. B. Pearce; Montreal Nurses Association, Mrs. H. Pollock, Miss H. O'Brien; Convener, Social Committee, Miss M. F. Currie.

A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

Hon. Presidents, Misses E. A. Draper and M. F. Hersey; President, Mrs. Stanley; First Vice-President, Mrs. LeBeau; Second Vice-President, Mrs. Scrimger; Treasurer, Miss Burdon; Recording Secretary, Miss G. Martin; Corresponding Secretary, Miss K. Jamer; Convener of Finance Committee, Miss Enright; Convener, Programme Committee, Mrs. Scrimger; Convener, Sick Visiting Committee, Miss Gall; Representative, "The Canadian Nurse," Miss E. Flanagan; Representative, Local Council of Women, Misses Hall, Yeates; Representative, Private Duty Section, Misses Steel, McCallum, Palliser, McKibbon.

A.A., WESTERN HOSPITAL, MONTREAL

Hon. President, Miss Jane Craig; President, Miss Marion Nash, 1234 Bishop St.; First Vice-President, Miss Bertha Birch; Second Vice-President, Miss Edna Payne; Secretary, Miss Ruby Kett; Treasurer, Miss Jane Craig; Conveners of Committees: Finance, Miss E. MacWhirter; Sick and Visiting, Miss B. Dyer; Correspondent to "The Canadian Nurse," Miss M. Hume; Representatives, Private Duty Section, Misses M. Tyrrell, H. Williams.

A.A., NOTRE DAME HOSPITAL, MONTREAL

Hon. President, Mother Dugas; Hon. Vice-Presidents Mother Mailloux, Rev. Sister Robert; President, Miss B. Lecompte; First Vice-President, Miss A. Hartenstein; Second Vice-President, Miss G. Dufresne; Secretary, Miss F. Massicotte, 2886 Holt St.; Assistant Secretary, Miss F. Ecuyer; Treasurer, Miss L. Boulerice; Conveners of Committees: Social, Miss L. Senecal; Nominating, Misses G. Beliale, E. Merissi, M. De Courville; Sick Visiting, Misses A. Martineau G. Gagnon, B. Lacourse.

A.A., WOMEN'S GENERAL HOSPITAL, WESTMOUNT

Hon. President, Miss E. F. Trench; President, Miss L. Smiley; First Vice-President, Mrs. Crewe; Second Vice-President, Miss N. J. Brown; Recording Secretary, Miss Commerford; Corresponding Secretary, Mrs. Chisholm; Treasurer and "The Canadian Nurse" Representative, Miss E. L. Francis; Sick Visiting, Mrs. Kirk, Miss Jensen.

Regular Meeting—Third Wednesday, at 8 p.m.

A.A. JEFFERY HALE'S HOSPITAL, QUEBEC

Hon. President, Mrs. S. Barrow; President, Miss E. Armour; First Vice-President, Miss H. A. MacKay; Second Vice-President, Miss E. Ford; Recording Secretary, Miss E. Douglas; Corresponding Secretary, Miss F. O'Connell; Treasurer, Miss E. McHarg; Representative to "The Canadian Nurse," Miss Doris Jack; Sick Visiting Committee, Misses Effie Jack, Cecile Caron; Private Duty Section, Miss C. Caron; Refreshment Committee, Misses A. Ascah, Ivy Nichol; Councillors, Miss F. L. Imrie, Mrs. D. Jackson, Miss C. Kennedy, Mrs. M. Craig, Miss Una Gale.

A.A. SHERBROOKE HOSPITAL

Hon. President, Miss H. S. Buck; President, Miss Ella Morrisette; First Vice-President, Mrs. Roy Wiggett; Second Vice-President, Mrs. Colin Campbell; Treasurer, Mrs. Adele Dyson; Recording Secretary, Mrs. Gordon McKay; Corresponding Secretary, Miss Evelyn L. Warren, Sherbrooke, P.Q.; Correspondent to "The Canadian Nurse," Miss Helen Todd.

MOOSE JAW GRADUATE NURSES' ASS'N

Honorary Advisory President, Mrs. Harwood; Honorary President, Mrs. Lydiard; President, Miss Cora M. Kier; Secretary, Miss B. Aldcorn, 202 Scott Bldg., Moose Jaw; Conveners of Committees: Social, Mrs. Stanfield; Press, Mrs. Lydiard; Constitution and By-laws, Miss French; Programme, Mrs. Young; Representative, Private Duty, Miss R. Cooper; Representative, Public Health, Miss Smith; Representative, Nursing Education, Mrs. Young; Correspondent to "The Canadian Nurse," Mrs. Archibald; Treasurer and Registrar, Miss Cora M. Kier.

A.A., REGINA GENERAL HOSPITAL

Hon. President, Miss K. M. Ross; President, Miss J. Jackson; 1st Vice-President, Miss M. Buker; 2nd Vice-President, Mrs. J. C. Black; Treasurer, Miss M. Wilkins; Secretary, Miss S. Pollock, General Hospital, Regina; Press Committee, Miss J. Burrows; Entertainment Committee, Miss M. McRae, Miss L. Turnbull; Refreshment Committee, Miss L. Blakely; Sick Nurses Committee, Miss F. Winterbotham.

A.A., SCHOOL FOR GRADUATE NURSES, McGILL UNIVERSITY, MONTREAL, P.Q.

Hon. President, Miss Mary Samuel; Hon. Vice-President, Miss Bertha Harmer; Hon. Members, Miss M. F. Hersey, Miss G. M. Fairley, Dr. Helen R. Y. Reid, Dr. Maude Abbott, Mrs. R. W. Reford; President, Miss Louise M. Dickson, Shriners' Hospital, Montreal; Vice-President, Miss Olga Lilly, Royal Victoria Maternity Hospital; Secretary-Treasurer, Miss Dorothy P. Cotton, 1227 Sherbrooke St. W.; Programme Committee, Miss M. Armstrong, 1230 Bishop St.; Representative to Local Council of Women, Miss M. Dobie, Royal Victoria Hospital; Representatives to The Canadian Nurse, Administration, Miss F. Upton; Public Health, Miss Lecompte; Teaching, Miss E. Hillyard, Children's Memorial Hospital, Montreal.

A.A. OF THE DEPT. OF PUBLIC HEALTH NURSING, UNIVERSITY OF TORONTO

Hon. President, Miss E. K. Russell; President, Miss W. Dawson; Vice-President, Mrs. W. Pearcey; Secretary-Treasurer, Miss A. Harrison, 45 Woodlawn Ave., E. Toronto, Ont.; Recording Secretary, Miss E. Ferguson; Convener of Social Committee, Miss C. Vale